NEXT ANNUAL SESSIONS
California Medical Association, Los Angeles, May 7-8-9-10, 1946.
American Medical Association, San Francisco, July 1-5, 1946.

CALIFORNIA AND WESTERN MEDICINE

Official Journal of the California Medical Association
FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 63
NUMBER 6

DECEMBER, 1945

50 CENTS A COPY
$5.00 A YEAR

CONTENTS AND SUBJECT INDEX

EDITORIALS:

On Motivating Influences and Personalities in Back of President Truman's Health (Sickness) Insurance Message, and Its Immediate Legislative Expression, Senator Wagner's New Bill—S. 1606.....259

On Selective Service Statistics—Two Interpretation Methods: One By the President of the United States, the Other by an Ex-President of the California Medical Association.261

On "Medical Care Inadequacies"—Where and Why: In Relation to Rural and Urban Practice, and Hospitals and Physicians.....262

EDITORIAL COMMENT:

Cardiotoxin Inhibitors. W H. Manwaring, Stanford University.....264

Penicillin Therapy of Rabbit Syphilis. W. H. Manwaring, Stanford University 265

SCIENTIFIC AND GENERAL:

Technique of Carotid Sinus Stimulation. John Martin Askey, Los Angeles 266

Variations in Size of the Human Stomach. Alvin J. Cox, San Francisco 267

Anatomical Demonstration of the Anovulatory Menstrual Cycle. G. L. Laqueur, San Francisco.....268

Introspection and the Orbital Cortex. J. M. Nielsen, Los Angeles.....269

President Harry S. Truman's Federal Health Insurance Plan.....270

Early Public Health in California. Guy P. Jones, San Francisco.....275

STATE ASSOCIATION ACTIVITIES:

Minutes: C.M.A. Council (329th Meeting, Held October 21, 1945).....277

County Societies: Membership; In Memoriam.282

California Physicians' Service.....285

Committee on C.M.A. Participation in the War Effort 286

Committee on Organization and Membership.....293

Committee on Public Relations.....293

Committee on Hospitals, Dispensaries and Clinics 295

Committee on Postgraduate Activities.....297

Committee on Public Policy and Legislation.....298

Committee on Health and Public Instruction.....306

MISCELLANY:

News 307

Press Clippings (Medical).....309

Medical Jurisprudence 311

Twenty-Five Years Ago 312

Board of Medical Examiners of the State of California 312

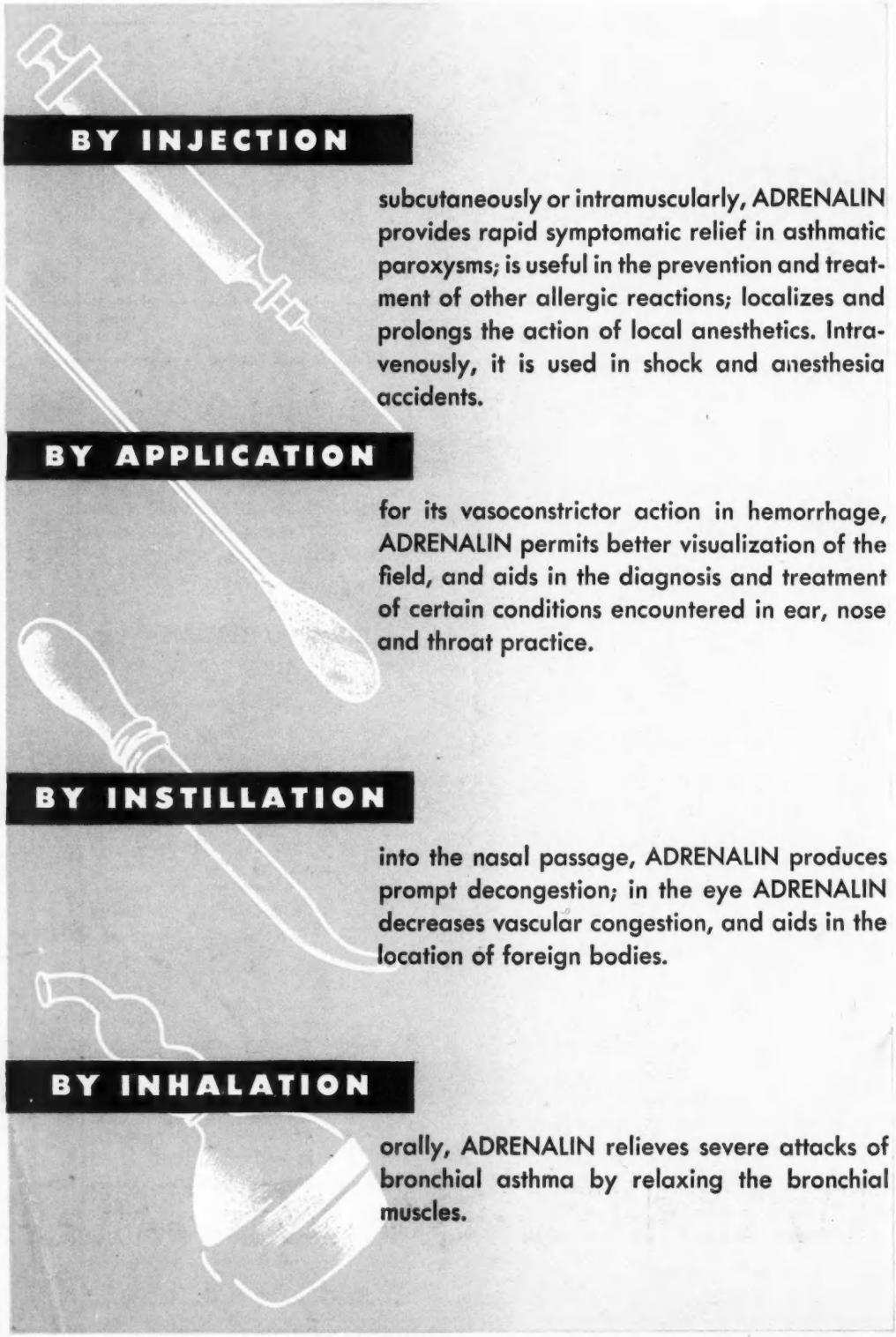
California Medical Directories.....Adv. pages 2, 4

Books Received .....Adv. page 7

ADVERTISEMENTS:

Index .....Adv. page 10

Owned and Published Monthly by the California Medical Association.
"Entered as second-class matter at the post office at San Francisco under the Act of March 3, 1879." Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917, authorized August 10, 1918.



BY INJECTION

subcutaneously or intramuscularly, ADRENALIN provides rapid symptomatic relief in asthmatic paroxysms; is useful in the prevention and treatment of other allergic reactions; localizes and prolongs the action of local anesthetics. Intravenously, it is used in shock and anesthesia accidents.

BY APPLICATION

for its vasoconstrictor action in hemorrhage, ADRENALIN permits better visualization of the field, and aids in the diagnosis and treatment of certain conditions encountered in ear, nose and throat practice.

BY INSTILLATION

into the nasal passage, ADRENALIN produces prompt decongestion; in the eye ADRENALIN decreases vascular congestion, and aids in the location of foreign bodies.

BY INHALATION

orally, ADRENALIN relieves severe attacks of bronchial asthma by relaxing the bronchial muscles.

CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 63 DECEMBER, 1945 NO. 6

California and Western Medicine

Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco
Phone DOuglas 0062

Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . . GEORGE H. KRESS, M. D.

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

George W. Walker, Chairman	Fresno	1946
F. Burton Jones	Vallejo	1947
R. H. Sundberg	San Diego	1948
George H. Kress, Secretary-Editor	San Francisco	ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON
Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

		PAGE
Index for This Volume	*(opposite)*	259
Editorials		259
Editorial Comment		264
Original Articles: Scientific and General		266
Minutes: C.M.A. Council		277
County Societies: Membership; In Memoriam		282
California Physicians' Service		285
Committee on C.M.A. Participation in the War Effort		286
Committee on Organization and Membership		293
Committee on Public Relations		293
Committee on Hospitals, Dispensaries and Clinics		295
Committee on Postgraduate Activities		297
Committee on Public Policy and Legislation		298
Committee on Health and Public Instruction		306
Miscellany: News		307
Press Clippings (Medical)		309
Medical Jurisprudence		311
Twenty-Five Years Ago; State Examining Board		312

EDITORIALS

ON MOTIVATING INFLUENCES AND PERSONALITIES IN BACK OF PRESIDENT TRUMAN'S HEALTH (SICKNESS) INSURANCE MESSAGE, AND ITS IMMEDIATE LEGISLATIVE EXPRESSION, SENATOR WAGNER'S NEW BILL—S. 1606

President Truman's Message.—On Monday, November 19th the public press carried the story of the "Message from the President of the United States, transmitting his request for legislation for adoption of a National Health Program," sent by President Truman to the 79th Congress.

On the very same day, press announcements also stated Senators Robert F. Wagner of New York and James E. Murray of Montana had introduced Senate Bill S. 1606, in which most of the recommendations contained in President Truman's message had been incorporated.

The Wagner law now proposed—S. 1606—differs in some important parts from the prior Wagner-Murray bill, S. 1050, submitted by Senators Wagner and Murray on May 24, 1945 (for reference to latter, see CALIFORNIA AND WESTERN MEDICINE, June, 1945, p. 307). Concerning such differences, more later.

However, former S. 1050 and present S. 1606 do contain many procedures much alike, not only one to the other, but also regarding provisions indicated in President Truman's message. Therefore, it would be fair to assume the Senators (or their sponsors, representatives, co-workers or assistants), must have had an audience with the President of the United States or his assistants, concerning the drafting of the message Mr. Truman deemed proper to send to Congress on November 19, 1945.

In making these and other comments that follow there is no desire on the part of CALIFORNIA AND WESTERN MEDICINE to give the impression that this journal would quarrel with the President of the Nation concerning some of the desirable objectives in his message, with which the medical profession has long been in accord. What critical comment is here expressed, is presented only because the future health needs of the people of the United States are the major issues under discussion,—vitally important subjects on which many physicians have a much more intimate knowledge, than is possessed by the lay Senators and others allied with them, who are the sponsors of legislation such as is proposed in S. 1606.

How Much Work Can Any One Man Do?—When, in contemplation, one considers the multitude of duties devolving upon the President of the United States, the hours given to commitments for diplomatic, political and other conferences, and that in the 24 hours of each day, some time must be taken by him for sleep and personal living, one may conclude (since the National Health Program is only one of other legislative measures of national and other importance now pending on his desk, such as housing and industrial reconversion, return of military personnel to our own shores), it was necessary for the President to rely in large part upon others in his entourage, to aid him in drafting the "National Health Program" as outlined in the message sent by him to Congress on November 19.

Since Senators Wagner and Murray are members of the President's own political party and have been the sponsors of previous Social Security legislation, it would not be unjust to assume that they have been included among the President's advisers. But, in Senators Wagner and Murray, again we deal with two lay legislators, likewise burdened with a multitude of political and other responsibilities. Moreover, their past support of proposed laws of the Wagner-Murray-Dingell type does not make them experts on best ways and means of maintaining a high quality of service in medical care, something far different from activities in their past professional and other careers. However, for argument's sake, it is agreed that the two Senators have read much on the subject of medical care. Also has been noted their willingness to accept many statements, both sound and unsound, used by them in support of some of their biased contentions.

* * *

Who Are the Background Agents or Agencies Sponsoring the Wagner and Similar Bills?—Since Senators Wagner and Murray have become such prominent protagonists of their theories—(a polite term for some of their promulgations)—it should be evident that they must have had behind them or have been associated with advisers, understudies or assistants who gave them the material they have seen proper to incorporate in drafts of legislation espoused by them.

If so, in turn, the query may be put: Who are some of the persons, groups or organizations that have given or suggested to Senator Wagner of New York, Senator Murray of Montana, and Congressman Dingell of Detroit, the information and material contained in the drafts of their respective bills?

On this point, the *Journal of the American Medical Association*, (*J.A.M.A.*, Dec. 1, 1945, p. 951) states:

"According to Arthur Sears Henning, 'the compulsory health insurance plan is chiefly the brainchild of Isidore S. Falk, research director of the Social Security Board, and Michael M. Davis, a member of the C.I.O. Political Action Committee.'"

An interesting article in *Medical Economics* (November, 1945, p. 36) refers to:

"a 'master plan' of the International Labour Organisation for socializing medicine in all countries of the world. No pipe-dream, this plan is already responsible for the establishment of state medicine in Chile and in New Zealand! Still more significant—though not generally known—is the fact that the Wagner-Murray-Dingell bill in this country was written largely by ILO (International Labor Organization) leaders and that those same leaders are a powerful element in the current campaign for its passage."

From the same article:

"What Americans serve among these experts? For medical planning, there are at least three (none of them physicians): Arthur J. Altmeyer, chairman of the United States Social Security Board; Isidore S. Falk, director of the SSB's Bureau of Research and Statistics; and Wilbur Cohen, its assistant director."

Also, from the article another paragraph, with an illuminating footnote:

"Of particular significance to the medical and allied professions is the International Labour Conference held in Philadelphia in 1944. At that session delegates* adopted a medical care recommendation embracing 114 detailed proposals to guide the member states in developing their health services. A majority of the 114 proposals are embodied directly or by implication in the Wagner-Murray-Dingell bill of 1945 (S. 1050)."

* * *

Physicians should give the President's Message and S. 1606 Careful Thought.—It is important that physicians keep in mind the background activities above referred to, since, if as stated, outside lay forces are the insidious or other promoters of the persistent propagandist campaigns on the desirability of having the United States legally adopt "Compulsory Health Insurance" (Compulsory Sickness Insurance) it follows that Doctors of Medicine practicing in the United States should immediately and collectively become aware of that important fact!

Otherwise, as in recent years, hundreds of thousands of Americans will continue to be misled through the unsound philosophies and misinformation so insistently put forward by the proponents of a regimented, compulsory system of medical care.

If legislation such as has been proposed by Senators Wagner and Murray is enacted into law, the physical and other welfare of present and future generations of Americans will be greatly imperiled! Physicians cannot evade their responsibility to aid in preventing such a calamity. Something more than "alertness against sabotage" is indicated.

It behooves physicians, everywhere, to study

---

* The U. S. delegation was composed of the following persons (none of them physicians) representing the groups specified:

Government—Senator Elbert D. Thomas (D., Utah), delegate; Assistant Secretary of State Adolphe A. Berle, Jr., substitute delegate for Miss Frances Perkins, the official delegate; Frieda S. Miller, Otis E. Mulliken, Charles W. Taussig, A. Ford Hinrichs, and Isador Lubin, Advisers.

Management—Henry I. Harriman, former president, U. S. Chamber of Commerce, delegate; Henry S. Dennison, Charles Redding, and Clarence G. McDavitt, advisers.

Labor—Robert J. Watt, American Federation of Labor, delegate; William Green, president, American Federation of Labor, adviser; George Meany, adviser.

the implications contained in President Truman's message*, and equally important, its legislative symbol, as expressed in the Wagner-Murray bill, S. 1606, which by indirection, now has the sanction of the Chief Executive of the United States.

To recapitulate:

(1) What kind of a medical profession would S. 1606 produce in the days to come?

(2) What kind of medical care would future generations of Americans receive under the proposed laws?

These are questions worthy of serious thought by all Americans.

ON SELECTIVE SERVICE STATISTICS—TWO INTERPRETATION METHODS: ONE BY THE PRESIDENT OF THE UNITED STATES, THE OTHER BY AN EX-PRESIDENT OF THE CALIFORNIA MEDICAL ASSOCIATION

Selective Service Statistics in President Truman's Message as a Basis for Later Recommendations.—Document 380 of the 1st Session of the 79th Congress is signed by Harry S. Truman, The White House, November 19, 1945. This document is President Truman's message on a "National Health Program" and was referred in the House of Representatives "To the Committee of the Whole House on the State of the Union and ordered to be printed".

Commencing at the bottom of the first page, President Truman started his statement concerning rejection statistics publicized by the U. S. Selective Service System. The figures presented were evidently intended to lay the foundation for subsequent comment, and to indicate changes that should be made in the existing system of medical care.

In other words, the Selective Service statistics were presumably used to furnish premises to conclusions applied and incorporated on the same day in Wagner-Murray bill, S. 1606.

The ease with which the Selective Service figures may be misinterpreted has been outlined in recent issues of *J.A.M.A.* and other publications.

Below appear excerpts from President Truman's message of November 19, after which are given quotations from the address of Dr. Lowell S. Goin, retiring president of the California Medical Association presented by him this year in Los Angeles, and printed in CALIFORNIA AND WESTERN MEDICINE for May, 1945.

Readers of CALIFORNIA AND WESTERN MEDICINE should peruse what President Truman had to say concerning Selective Service figures, and then scan Dr. Goin's analysis and breakdown of practically the same statistics, given some six months before President Truman sent his "National Health Program" to Congress.

* * *

How President Truman used Selective Service Statistics.—Herewith, excerpts from President Truman's message:

"The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our Nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently in terms which all of us can understand.

"As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 per cent of all those examined. The percentage of rejection was lower in the younger age groups and higher in the higher age groups, reaching as high as 49 per cent for registrants between the ages of 34 and 37.

"In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the armed forces for diseases or defects which existed before induction.

"Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

"These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives."

* * *

Selective Service Statistics as Broken Down by Ex-C.M.A. President Goin.—Having read the above, check may now be made with Dr. Goin's analysis:

"SELECTIVE SERVICE STATISTICS

"Since the five million 4F's are so frequently invoked, and since it is at first glance so shocking a figure, let us examine it in some detail. One difficulty with the argument is that intellectually it is not very honest. In Senator Pepper's interim report the figure is announced on page one not as five million, but as four-and-one-half million but on page three of the same report the graph discloses the true figure to be 4,217,000. An error of 13½ per cent can scarcely be considered insignificant.

"Of the total number rejected 444,800 were rejected as manifestly disqualified, that is to say the totally blind, the totally deaf, the deaf-mutes, the legless, the armless and so forth. It seems perfectly obvious that no program of medical care could have influenced this figure.

"701,700 were rejected for mental disease. Again I don't know of a program of medical care which would have prevented mental disease in these unfortunate people.

"582,100 were rejected for mental deficiency, that is to say that they were the imbeciles, the idiots and the morons. The most casual knowledge of eugenics would persuade anyone that this group does not constitute a medical problem, and these three groups together reach the large total of 1,727,600.

"When these have been excluded there remain 2,426,500 or somewhat less than half of the originally claimed five-million.

"Of this group 320,000 were rejected for muscular-skeletal defects, that is to say the clubfoot, the paralytic, the withered arm, the congenitally dislocated hip and so forth. Again I wonder what program of medical care might have made this group fit for military service.

"280,000 were rejected for syphilis. The statute books are already loaded with laws regarding syphilis. There

---

* In this issue President Truman's Message appears on page 270. Press comments on pages 298-304.

is probably not a community in the United States in which a person afflicted with this disease cannot secure treatment from the Department of Public Health. How, then, would compulsory health insurance have eliminated this group?

"220,000 were rejected for hernia. Hernia is a congenital defect and if a person is born with a defective inguinal or femoral canal he is likely to have a hernia and medical care has nothing whatever to do with the occurrence of hernia.

"160,000 were rejected for 'eyes.' Since eyes would seem to be useful adjuncts to men who were to be soldiers or sailors I presume that this means defective vision. If one is born with an eyeball too long or too short or one which is not a globe one will either wear glasses or not see very well and medical care has nothing whatever to do with it.

"Thus about one million more have been eliminated and the number of rejections on a basis of lack of medical care is about 1,500,000. Whether any program of medical care would have materially reduced this number is problematical.

"If the proponents wish to rest their case upon the need shown here (and they have made a great deal of it), I am content."

* * *

Is it now in order to ask of CALIFORNIA AND WESTERN MEDICINE readers, this question:—

Having read both statements, what are your own conclusions?

ON "MEDICAL CARE INADEQUACIES"—WHERE AND WHY: IN RELATION TO RURAL AND URBAN PRACTICE, AND HOSPITALS AND PHYSICIANS

"Medical Care Inadequacies"—A Much Abused Term.—The term, "Inadequacies in Medical Care," has been subjected to so much misuse that whatever meaning it may still possess, depends in good part on the person who uses it.

That some individuals do not receive indicated medical care is not denied, and physicians have called attention thereto over many years. However, even though the inadequacies are related to disease and injury, to then place the blame for such upon the medical profession, is an evidence of lack of knowledge of actual facts, confused thinking and erroneous reasoning.

Proponents of "compulsory health insurance" are particularly prone to commit this offense. For, once having stated one imaginative premise (inadequacies of medical care), and their own opinion of the cause (the medical profession), they then use the term and the cause they have put forth, as premises from which to draw the conclusion that medical practice must be radically changed! (Inferentially, also that they, the reformers, are the proper persons to do this!)

The particular change they envision concerning medical practice may be summed up as "socialized medicine" (state medicine—political medicine), to be put into operation through a federal compulsory health (sickness) insurance law.

As stated above, the medical profession has long recognized that under certain conditions and in some places in the United States, inadequacies of medical care, may and at times, do exist. For discussion purposes, it may be worth while to call brief attention to some of the reasons why inadequacies are present in rural and urban areas, and the ways in which hospitals and physicians may be concerned therewith.

* * *

(1) Inadequacies in Rural or Sparsely Settled Areas.—California contains many sparsely settled areas in its expansive geographical domain. By the State's constitution, a county in California may erect and maintain a county hospital. Let us cite, as an instance, Alpine County, a Mother-Lode, Forty-Niner county,—credited in the 1940 census with a total population of 323 persons. How could that county erect and maintain a county hospital?

Other California county examples are Mono with 2,299, Sierra with 3,025, Trinity with 3,970 residents. California itself covers an area of 158,693 square miles. By contrast, Rhode Island has only 1,214 square miles, and Massachusetts, 8,257 square miles. Mono County with its population of 2,299 has one lone physician, and covers 3,030 square miles, an area almost half the size of Massachusetts!

In the wide open spaces of the Great West, portions of woodlands in the northern states, and the marshy and other sparsely settled regions of southern commonwealths, similar population figures may be found.

Yet, the proponents of compulsory socialized medicine plans not infrequently refer to the number of counties in the United States that do not have the advantages of up-to-date hospitals, health centers and other modern-day medical equipment, as if this deficiency in "number of counties" was a terrific arraignment!

The fallacy of such misleading information or reasoning, especially when used as texts or pleas to emphasize inadequacies in medical care that may exist in the United States, becomes evident when figures such as those above given for some of California's counties are taken into consideration.

It would be well if the Do-Gooder (often salaried) proponents who presumably have dedicated themselves to the campaign for elimination of medical care inadequacies, would first consider what are practicable and available ways and means to bring medical practice as it is carried on in metropolitan areas, to these less fortunately situated regions of our land.

It should be self-understandable that small county units often do not possess the taxation resources that would permit them to build (and even more difficult, maintain from year to year) the hospitals, health centers, laboratories, etc., etc., concerning which the reformers often prate at great length, and which, some of them seem to think, every citizen in the Union should supposedly have at his immediate beck and call.

Fortunately, at least in California, the public highways are so numerous and of such excellent construction that for patients suffering from serious illnesses or injuries, it is possible for the local physician to arrange for transportation to

a not too-far-distant consultant and hospital, so that human life is rarely menaced in these small population places.

A phase of the medical care problem for these rural and sparsely settled regions that do not possess the population or resources to enable a physician to properly maintain himself and his family, brings up the thought that through subscription by local citizens (or through single local, or perhaps, joint local, state and federal coöperation), it may be possible to establish subsidies that could be paid to a physician who would go in and practice in such a district. That plan is in operation in some Canadian communities.

The costs of such a subsidy procedure—in the limited number of places where the same may be indicated,—would be as nothing, compared to the millions upon millions of dollars of federal funds that would be needed under a compulsory and socialized, political medicine plan, such as would be created by the Wagner-Murray-Dingell bill, S. 1606, presented to Congress on November 19, 1945.

* * *

(2) Hospital and Health Centers in Urban and Rural Environments.—By their very nature, hospitals are expensive expressions of modern-day American civilization. In one sense, they are hotels for sick and injured people, operating in part as such; but with much greater costs in capital investment and maintenance, due to expensive laboratory and other equipment, and larger personnel, such as technicians, trained dietitians, and professional nurses on 8 hour shifts.

In metropolitan areas, private hospitals in the past have usually come into being when sufficient public need, demand and support have been given. In such densely populated places, public as well as private hospitals of high standard are generally maintained. Through the opportunities given members of attending staffs to meet without great loss of time, these hospitals practically become health centers, their hospital staffs working with local medical societies and public health administrators to promote excellent work in both preventive and curative medicine.

However, to erect suitable buildings and try to maintain modern hospital structures in places where only a small number of physicians and professional nurses are in practice and where philanthropic or tax moneys are not available, would lead to nothing else than disaster. Indeed, such ill-considered attempts would change the existing system into something that would create not better, but poorer medical care. The Do-Gooder Reformers who advocate their vagaries on medical care, should take time for some quiet thinking before they expound their theoretical visions. What some of these propagandists need, above all else, is less cheap pseudo-altruism, and more common sense realism.

* * *

(3) The Physician.—The promoters of socialized medical plans, as a class, seem to derive special joy in assailing organized medicine (American Medical Association, State Medical Societies, County Medical Units). By them, the 120,000 well educated and professionally trained Doctors of Medicine who are members of these organizations are looked upon as a group of reactionaries, bound by union or worse rules, and not daring to speak up in opposition to the officers, whom they have elected (democratically) to be their leaders. What a misrepresentation!

Now, let us ask, who are these physician men and women who have taken upon themselves to become disciples of the healing art? The great majority either hold liberal arts degrees or have received equivalent education. In addition they have pursued courses of professional training covering four years, to which have been added one or two additional years of hospital internship and residency experience. All this, at a cost to each of them of some of the best years of their lives spent in earnest study, and at a money price of about ten to twenty thousand dollars.

As individuals with such educational backgrounds, they hope to make similar opportunities available for their children. In cities, they can obtain such. In isolated or sparsely settled places, such opportunities at times do not exist. Therefore, there is a natural reluctance on the part of many physicians to establish themsleves in practice in sparsely settled communities. Yet, by inference, the reformers hold that physicians should and must be so provided. Query: How can this be accomplished, legally?

For, by what American law can a law-abiding individual be forcibly taken from one community by the government, and made to settle in some other community? There is no such statute. How then, will the Do-Gooder visionaries secure the physicians to go to out-of-the-way places, unless subsidy plans or equivalent measures to provide for decent compensation are first provided?

If a beginning must be made to bring about a migration of physicians, from metropolitan or other areas to less settled communities, why should not the Do-Gooder Reformers first work out practical plans along lines noted above, instead of presenting their expostulations on behalf of visionary and non-practical schemes? These propagandists might better spend some of their time in constructive thinking instead of loose talking.

* * *

In Summary.—In the above have been charted a few of the practical problems that should be considered when President Truman's message to Congress and Wagner-Murray bill S. 1606, come up for consideration.

No man can prove that individually and collectively, members of the medical profession have not as much love for their human fellows as any other profession or group.

Since Doctors of Medicine have more practical experience concerning medical practice and needs, it follows that the opinions of physicians thereon should be worthy of serious and special considera-

tion. Not so, presumably, in the opinion of the Do-Gooder Reformers, who have been so busy in the drafting of sickness insurance laws in the construction of which, organized medicine through its national, state and local units is nearly always forgotten!

Hence, there is no other course for the medical profession to follow, than to give battle to the supposed reformers, who, through revolutionary, impractical schemes, would establish a compulsory political bureaucracy designed to supervise political medical care. The institution of such a system would destroy the fine advances that have been made through scientific medicine, under the evolutionary system of medical practice now existing in the United States.

As loyal Americans, the physicians of the United States will fight to preserve for their lay fellow citizens, those forms of medical practice that have given to our country the lowest morbidity and mortality rates of any civilized nation comparable to our own in diversity of domain and industrial, agricultural and welfare environments.

To do less, would be lacking in loyalty to our people and our profession.

EDITORIAL COMMENT†

CARDIOTOXIN INHIBITORS

Isolation of a hitherto unsuspected protective internal secretion from the heart muscle is reported by Cantoni and Bernheimer[1] of the Department of Pharmacology and Bacteriology, New York University College of Medicine. The new myocardial internal secretion will neutralize (or otherwise inhibit) multilethal doses of streptococcus toxin, and toxic products from certain other pathogenic bacteria.

Discovery of the new myocardial protective hormone was a by-product of a study of the pharmacological action of various bacterial toxins on the isolated frog's heart.[2] Streptococcus pyogenes was grown in mass culture in Bernheimer's[3] synthetic medium. After 20 hours growth at 35°C. the fluid culture was refrigerated over night, then centrifuged. The resulting supernatent fluid was concentrated 300-fold by repeated evaporation and repeated dialysis against saturated or half-saturated ammonium sulfate. This was followed by dialysis against running tap water. The resulting dialyzed concentrate was found to be strongly hemolytic for human r.b.c., its average hemolytic titer being 100,000 Bernheimer units[4] per cc.

The concentrate was diluted 25 times with Ringer's solution containing cystein in a concentration of 1:1000 to serve as an activator. The activated dilute concentrate was then administered to an isolated frog's heart by means of a Fühner cannula, and allowed to remain in the heart for 23 minutes. No toxic reaction was recorded other than a slight increase in systolic amplitude. In other tests, the activated dilute concentrate was removed from the heart at the end of 5 minutes, and the heart washed twice during the next 10 minutes with Ringer's solution. A second dose of dilute concentrate identical with the first was then introduced into the Fühner cannula. Within 30 seconds decreased relaxation of the ventricle was recorded, increasing to a complete systolic contracture and standstill by the end of 90 seconds. In some unknown way contact with the apparently non-toxic first dose of streptococcus concentrate "sensitized" the heart so that the second dose of the same concentrate produced a rapidly lethal effect.

Quantitative studies showed that this terminal toxicity could not be accounted for as a simple summation of two subthreshold doses of streptococcus toxin. It was further found that fluid removed from the ventricular cavity 5 minutes after instillation of the first dose contained sufficient streptococcus "inhibitor" to neutralize from 5 to 10 lethal doses of the streptocardiotoxin if given to a previously sensitized heart. As a result of release of this inhibitor the heart muscle was presumably depleted of its normal chemical defense, and was thus rendered hypersusceptible. Preliminary tests suggest that this inhibitor will also neutralize type II pneumococcus hemolysin and Cl. welchii theta-toxin.[5]

The antitoxic action of this inhibitor was confirmed on mice. It was found that 0.5 cc. of a 1:25 dilution of activated streptococcus concentrate injected intravenously would kill 16-20 gram mice within 5 minutes. Of 17 mice which received this dose plus 0.125 to 0.50 cc. of inhibitor fluid, 15 survived longer than 5 minutes and 10 survived indefinitely. Of 11 control mice which received the same toxin but no inhibitor, all 11 died within 5 minutes.

The inhibitor is non-dialysable through a cellophane membrane, is koktostable and chloroform-soluble. It is presumably a lipid, having no chemical similarity with a humoral antibody. If confirmed, these facts suggest that the New York pharmacologists have opened up a new field of immunologic research, whose practical results may in time rival those from conventional antibodies.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCES

1. Cantoni, G. L., and Bernheimer, A. W.; J. Exp. Med., 81:307 (March), 1945.
2. Bernheimer, A. W., and Cantoni, G. L.; J. Exp. Med., 81:295 (March), 1945.
3. Bernheimer, A. W.; Gillman, W.; Hottle, G. A., and Pappenheimer, A. M.; J. Bact., 43:495, 1942.
4. Bernheimer, A. W.; J. Exp. Med., 80:309, 1944.
5. Clark, A. J.; J. Physiol., 47:66, 1913-14.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

PENICILLIN THERAPY OF RABBIT SYPHILIS

In a posthumous paper, Raiziss[1] of the Dermatological Research Laboratory, Philadelphia, summarizes his accumulated experimental evidence as to the therapeutic value of penicillin in the treatment of experimental testicular syphilis in rabbits. In a preliminary test[2] he had previously reported that intramuscular injection of 2,500 Oxford units of penicillin sodium in aqueous solution twice daily for 8 consecutive days, rendered the testicles apparently free from spirochetes by the 14th day, and led to apparently complete healing by the 42nd day. Slightly better results were obtained by injecting 5,000 Oxford units in peanut oil once daily for 8 consecutive days, spirochetes disappearing by the 8th day, with apparently complete healing by the 35th day.

Raiziss recognizes that return of the testicles to apparently normal following antisyphilitic treatment does not constitute proof of a complete cure. The popliteal lymph nodes of the treated rabbits were therefore removed 100 to 115 days after the testicles had become apparently normal, and tested for spirochetes by intratesticular transfer into normal rabbits. In all cases, such transfer gave negative results, indicating a complete cure.

Since making his preliminary report, other syphilitic rabbits have been given larger doses, such as 5,000 units per Kg. of body weight in peanut oil, twice daily for 8 consecutive days, or a total of 80,000 Oxford units during the 8-day period. These rabbits were freed from spirochetes and returned to normal sooner than in the first tests, late popliteal transfer indicating a complete cure. From these more favorable results, Raiziss recommends that for a 60 Kg. patient, 300,000 Oxford units in peanut oil should be injected intramuscularly twice daily for a period of 8 days, a total of 4,800,000 Oxford units for the 8-day period. He believes this method is simpler and would give more satisfactory results than the conventional continuous drip method.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCES

1. Raiziss, G. W.; Science, 102:329 (Sept. 28), 1945. (Dr. Raiziss died July 16, 1945.)
2. Raiziss, G. W.; Science, 100:412 (Nov. 3), 1944.

Medical Group Union Formed in Los Angeles

The CIO State, County and Municipal Workers announces that it has unionized the Los Angeles County Bureau of Medical Service and that it has plans for a joint union-management committee to operate within the bureau.

About 100 persons work in the bureau which is headed by Mrs. Myrtle Silver. Its employees determine whom the County of Los Angeles shall admit to its General Hospital and various institutions for county aid. They also advise the families.

The union announced also that it is proposing that its members be required to work only 40 hours instead of 48 hours, but that they be paid the same for the shorter week.

H. S. Jung, regional director of the CIO union, said he has notified A. J. Will, head of the Los Angeles County Department of Charities.—Los Angeles *Times*, November 30.

Governor Warren Will Call Special Session

Governor Warren on November 9, disclosed that he would call a special session of the Legislature to deal with postwar problems some time before federal funds for maintenance of child care centers expire.

While no date was set, one ranking state official said the Governor was considering issuing the call for January. (Date has been set for January 7.)

California State Health Plan Debated

Arguments similar to those heard when the proposal was turned down by the Legislature were voiced on November 15, when Governor Earl Warren's compulsory health insurance plan was debated at the first meeting of a State senate interim committee.

William T. Sweigert, executive secretary and spokesman for the Governor, declared that California's failure to take constructive action towards an adequate medical care program will invite the alternative of highly centralized Federal control.

Mr. John Hunton, executive secretary of the California Medical Association, held that "the proper quality and quantity of medical service can be better accomplished by voluntary means than by compulsion."

The committee that heard the arguments is headed by Senator Byrl Salzman, who announced the appointment of Dr. Russell V. Lee of Palo Alto as its research consultant and advisor.

Mr. Sweigert told the session that a plan such as that advocated by Governor Warren is the only method of overcoming "unpredictability of costs" and of providing adequate medical and hospital care for the average Californian.

He appealed to all elements of the medical profession to "get together" on a sound program and to cease regarding the Governor's plan as "socialized medicine."

Contending that voluntary systems are best, Mr. Hunton and Dr. P. K. Gilman, Medical Association president, said steps were being taken to inform the public of existing voluntary systems and induce greater enrollment.

Professor Samuel C. May of the University of California predicted that doctors, insurance carriers and others opposing health insurance will join in a "concentrated attack" on all such proposals.

Speaking for the State Federation of Labor, Charles P. Scully declared the Federation is agreed there "obviously is a great need for a program."

Mrs. George H. Hoxsie submitted a statement of the policy of the California League of Women Voters, indorsing a program closely paralleling that sponsored by the Warren Administration.

Assembly Committee on Health Plan Meeting

Public health insurance programs were under discussion on November 9, at the opening session of a two-day meeting of the State Assembly interim committee on health care.

Committee members were meeting with representatives of the Blue Cross and the California Physicians' Service in the State Railroad Commission's courtroom.

Members of the two health associations presented their views on insurance programs to the committee, which recommended a plan for state public health insurance to the Legislature after hearing testimony of health groups in cities throughout the stat.e

The committee, which was created by the last Legislature to investigate public health insurance programs after the defeat of the compulsory payroll deduction plan sponsored by Governor Warren, is under the chairmanship of Ernest Geddes, Pomona assemblyman.

ORIGINAL ARTICLES

Scientific and General

TECHNIQUE OF CAROTID SINUS STIMULATION*

JOHN MARTIN ASKEY, M. D.
Los Angeles

PAROXYSMAL auricular tachycardia is encountered sooner or later in every general physicians practice, and constitutes a minor or major cardiac emergency depending upon the condition of the heart itself and the duration of the tachycardia. It responds to various treatments, often stopping spontaneously. Pressure over the carotid sinus is one of the measures used most frequently in stopping such attacks. The success of this maneuver depends upon eliciting a strong reflex vagal cardiac effect by mechanical stimulus of the nerve filaments in the carotid sinus. There are two requisites for the maneuver to be effective. First, precisely to locate the carotid sinus, second, to apply adequate stimulation. It is probable that many failures to stop paroxysmal auricular tachycardia are due to failure properly to locate the sinus, inasmuch as pressure over the common carotid artery below the sinus has no effect. There are few detailed descriptions of the application of this maneuver, and many medical students and physicians, we believe, are unfamiliar with the details of the technique.

PROCEDURE

The technique we use is as follows:

The patient sits upright in bed or in a chair. The chin is elevated to make the carotid artery more readily palpable. The patient is instructed to hold the stethoscope over the apex of the heart with the right hand. (Fig 1.) Taking his position in front and to the left of the patient, the doctor applies his right hand to the left side of the patient's head. With two or three fingers of his left hand, he then locates the pulsation of the right common carotid artery and follows it up the neck to about the level of the upper border of the thyroid cartilage, where the carotid sinus may be felt as a bulge at the bifurcation of the common carotid artery. (Fig. 2.) If the bulge is not felt definitely, the point of greatest pulsation usually will be the correct site. With the fingers of the left hand, pressure is then firmly made over this bulge backward and medially firmly enough completely to compress the artery. A slow vertical and rotary massage over the sinus is employed in order to stimulate the maximum number of nerve filaments. Adequate pressure is necessarily firm but not severe. It is not unusual for the patient to wince from the pressure. If the sinus is correctly located and massage is adequate, the tachycardia usually will terminate abruptly after a few seconds. It is not more effective, nor is it wise, we believe, to press longer than 5 to 10 seconds at a time. If the tachycardia does not stop after pressure on the right side, pressure may be made over the left carotid sinus, although it is seldom successful if pressure over the right carotid sinus fails.

COMMENT

By the above method, the carotid sinus is usually located readily, counter-support of the head to allow firm

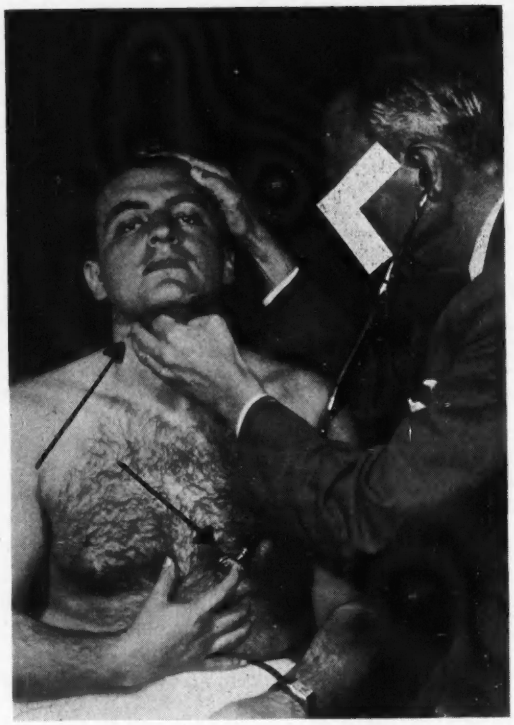


Fig. 1.—Position of patient and examining physician.

pressure is supplied, continuous auscultation of the heart to indicate the exact moment of cessation of the tachycardia is possible, and observation of the patient is permitted. Some advise standing behind the patient while applying pressure. It is always wise, we believe, to observe the patient's face at any time carotid sinus pressure is employed. Besides syncope which results from bradycardia or hypotension, sudden syncope due to a direct cerebral effect is also mediated through the carotid sinus nerves. Such a syncopal reaction usually occurs abruptly without any preceding bradycardia and is usually

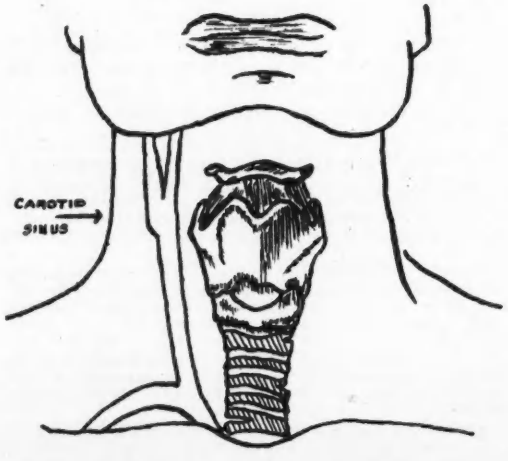


Fig. 2.—Topographical location of carotid sinus.

* From the Department of Medicine, University of Southern California School of Medicine.

Acknowledgment of assistance in the preparation of this paper is made to Dr. Joseph A. Pollia.

preceded by sudden facial blanching. Such a reaction is rare in paroxysmal supraventricular tachycardia, but may occur and one is always prepared if the technique includes standing in front of the patient. In case of a syncopal reaction, the hands are in ready position to hold the patient and to lower him into a recumbent position.

CONCLUSION

Carotid sinus stimulation also has a place in the differentiation of arrhythmias.[1] It has been used to identify the hypersensitive carotid sinus syndrome, and as a routine in complete neurological examinations. Its employment for the latter purpose in the middle aged or elderly individual with arteriosclerosis should be cautiously weighed. Untoward cerebral accidents have occurred[2] and although these are forunately very rare, the possibility should be recognized and should enter into the consideration of the indications and contraindications for the use of the maneuver.

1930 Wilshire Boulevard.

REFERENCES

1. Levine, S. A.: Clinical Heart Disease, W. B. Saunders Co., Philadelphia and London, 1945, third edition, p. 326.

2.(a) Marmor, J., and Sapirstein, M. R.: Bilateral Thrombosis of Anterior Cerebral Artery Following Stimulation of a Hyperactive Carotid Sinus, J.A.M.A., 117:1089 (Sept. 27), 1941.

b. Data of California Heart Association (to be published).

VARIATIONS IN SIZE OF THE HUMAN STOMACH*

ALVIN J. COX, M. D.
San Francisco

TEXT books provide few and sometimes conflicting data regarding the size of the human stomach. Cunningham's Textbook of Anatomy contains the statement, "probably no organ in the body varies more in size within the limits of health than the stomach"; however, it is not clear whether "size" refers to weight or capacity, post mortem measurements of which are recognized to be misleading. Specific records of stomach size are not common, but several have been reported. All deal either with weight of the organ or with its capacity. Ross[1] reports the normal stomach capacity as 1-2 liters and the normal weight as 125 to 175 grams. Reed[2] notes the "average capacity" as 1600 to 1700 cc. and the normal weight range as 113.4 to 141.75 grams.

POST MORTEM MEASUREMENTS

Measurements of the capacity of the stomach post mortem are not reliable because of the impossibility of standardizing the degree of distension of the organ. Differences in the amount of muscle, rigor mortis, and other post mortem changes may influence the distensibility. A more reliable index of stomach size is the total area of the mucosa after it is spread so that all folds are removed. In stomachs which are not distended, the mucosa, because of its folds, has an area greater than that of the muscular wall. When the latter is stretched the mucosal folds are progressively flattened until they disappear and the mucosal surface is uniformly parallel to that of the muscle. This disappearance of the mucosal folds on stretching of the stomach is an end point which can be recognized readily. Although most methods of stretching cause some further tension to be applied to those portions of the mucosa, where folds are absent or disappear early, this does not lead to much increase in area because gastric mucosa can be stretched only slightly after the folds are flat, and will tear before there is much increase in area. This standardized stretching procedure is easily accomplished with the excised opened stomach and such a method has been used in this study.

One hundred and twenty-six human stomachs obtained at autopsy have been measured. Most of the specimens were obtanied within six hours of the time of death, and none has been included in which post mortem digestion of the mucosa has been been more than superficial. The stomachs have been opened along the greater curvature and have been pinned to a board in the stretched position before fixation in 4 per cent aqueous formaldehyde. After fixation, maps have been prepared by tracing the outline of each specimen on paper, and the areas of gastric mucosa have been measured from the maps by means of a planimeter. Average values for stomach mucosal area obtained in this way are 843 sq. cm. for males and 763 sq. cm. for females.

All of the stomachs were weighed after formalin fixation and removal of the attached ligaments and masses of fatty tissue, and the value was corrected later by subtracting the weights of the attached portions of esophagus and duodenum, which were removed after histological sections had been prepared. The average stomach weight was 165 grams in males and 150 grams in females. Fig. 1 shows the relation between the mucosal area and the stomach weight in the individual cases. The greater weight of those stomachs having large mucosal areas indicates that differences in the latter are not due merely to variation in degree of stretching. Preliminary observations show the greatest thickness of mucosa in the stomachs with large areas, so it is apparent that the mucosal area provides a rough index of the quantity of mucosal tissue present.

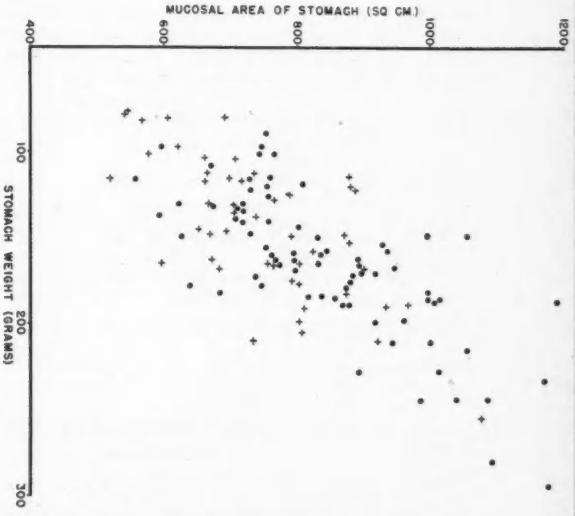


Chart 1.—Differences in Size of the Human Stomach (based on measurements of 126 stomachs).
Solid circles represent males; crosses represent females. One additional stomach from the series (area 1536 sq. cm. and weight 453 gms.) was so much larger than the others that it was not included in this chart.

The extreme values for mucosal area in this series are 520 and 1536 sq. cm., and the range of stomach weight is from 77 to 453 grams. These represent variations of three and six fold respectively. The differences are not related to age of the patients, which ranged from 19 to 83 years.

* Read before the Section on Pathology and Bacteriology at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

From the Department of Pathology, Stanford University School of Medicine, San Francisco.

Similarly, body height and body weight have shown no close correlation with stomach size. The sex difference recorded above is no greater than sex differences in weights of other organs, and is considerably smaller than differences within each sex group. Therefore, it has been concluded that some other influence is largely responsible for determination of stomach size.

COMMENT

It is possible that functional factors may contribute to stomach size. This may bear a relationship to work performed similar to that suggested by Addis and co-workers[3,4] for the heart, kidney, liver, and gastrointestinal tract of experimental animals, but it has been impossible to demonstrate such an influence since no reliable information is available concerning the eating habits of the patients in this series. The stomach size bore no apparent relation to the nutritional state of the individuals.

Many diseases are represented in this series of cases, but most do not occur with sufficient frequency to permit valid conclusions regarding their relation to stomach size. No constant relationship to specific disease has been observed. Cases of carcinoma of the stomach, which greatly modifies the stomach size, have not been included in this series. Other gastric lesions were not obviously related to the size of the organ. Several stomachs exhibiting gastric ulcer showed little deviation from the average. As a group, the cases showing the changes of so-called chronic atrophic gastritis had normal sized stomachs, although two of four cases of pernicious anemia with severe mucosal changes had areas of 542 and 546 sq. cm. respectively. These were two of the three smallest stomachs in the series.

Two other groups of cases showed variations from the average stomach size which can only be mentioned because, due to the small number of cases, the significance of the differences is questionable. Stomachs from eight patients with diabetes mellitus had an average mucosal area which was 23 per cent greater than that of non-diabetic patients. In 17 stomachs from cases of chronic or healed duodenal ulcer, the average area was 9 per cent greater than that of cases without duodenal ulcer. There was no anatomical obstruction of the pylorus in any case. Clarification of the reasons for these apparent differences will require further observation.

SUMMARY

Measurements of mucosal area and total weight have been made in 126 human stomachs obtained at autopsy. Variations in stomach size are significant but cannot yet be explained. Differences in sex, age of patients, or body size do not account for the differences in the stomachs. Possible relationships to other conditions have been discussed.

2398 Sacramento Street.

REFERENCES

1. Ross, J. M.: Post Mortem Appearances, Fourth Edit., London, 1939.
2. Reed, B.: Diseases of the Stomach and Intestines, New York, 1904.
3. Walter, F., and Addis, T. Organ Work and Organ Weight, J.E.M., 69, 467, 1939.
4. Addis, T.: Hypertrophy of the Gastro-Intestinal Tract and High Residue Diets, Am. J. Physiol., 99, 521, 1932.

This government, with its institutions, belongs to the people who inhabit it. Whenever they shall grow weary of the existing government, they can exercise their constitutional right of amending it, or their revolutionary right to dismember or overthrow it.

—Abraham Lincoln, *Speech*, at first Republican State Convention in Illinois, 1856. Quoted by Theodore Roosevelt in address before Ohio Constitutional Convention, Columbus, February, 1912.

ANATOMICAL DEMONSTRATION OF THE ANOVULATORY MENSTRUAL CYCLE*

G. L. Laqueur, M. D.

San Francisco

In 1923, George W. Corner,[1] and in 1927, Corner,[2] Carl G. Hartman,[3] and Edgar Allen[4] reported that recurrent hemorrhage from the healthy uterus occurred in the macacus rhesus without ovulation and in the absence of premenstrual changes in the endometrium. Corner[2] suggested the possibility that a similar type of menstruation might be found in women. Since these original publications, a large body of information on the anovulatory cycle of the monkey has been carefully accumulated.[5,6] Using the castrated monkey as experimental animal, Edgar Allen[4] demonstrated that discontinuation of estrogen treatment would result in menstruation and his observations became the basis for the estrin deprivation theory of menstruation. The similarity of the bleeding phenomena between the anovulatory and ovulatory menstruation was further emphasized and rather convincingly demonstrated in the experiments of Markee[7] who studied the bleeding mechanism in intraocular endometrial implants in both conditions.

In women, a small number of cases have been reported in which the examination of the pelvic organs free of pathology offered sufficient proof to make the diagnosis of an anovulatory cycle.[8,9,10] On the other hand, most of the textbooks on this and related subjects state that anovulatory cycles probably occur much more frequently and the condition has become a rather well recognized endocrine entity.[11,12] Statements as to the frequency of this type of menstrual cycle are of necessity vague, although clinicians usually point out that the incidence is probably higher during the first years following the menarche as well as during the period preceding the menopause. However, anovulatory cycles may be found at any time during the reproductive period of life. (Example. Case 8 of Bartelmez.)

REPORT OF CASE

The present report is of a 12 year old girl who came to autopsy 26 hours after a spontaneous intracerebral hemorrhage with no history of trauma. The girl had been well except for whooping cough at 5 and chicken pox and mumps between the ages of 6 and 8. Her menarche was 4 months prior to death, and four menstrual periods had been regular and without pain. Her last menstrual period was one week before death.

At autopsy, the girl was well developed including the secondary sex characteristics. She weighed 105 pounds and was 5 feet 2 inches tall. The brain showed a large defect in the frontal and parietal lobes filled with blood. The hemorrhage had occurred from one of multiple malformations in the wall of the cortical branches of the left middle cerebral artery. There was no evidence of trauma or previous hemorrhage. The remaining tissues and organs were normal although several sections taken from the aorta showed multiple microscopic areas of medial degeneration. Examination of the genital organs revealed the following: The uterus was normal, the length of the uterine body approximately equalled that of the cervical canal and cervix. The endometrium was regular, thin, and firm, measuring 1 mm. in thickness. The tubes were normal. The surfaces of the ovaries were smooth except for a small dimpled area in the left ovary. On sectioning, both ovaries contained numerous small cysts measuring up to 0.7 cm. in diameter. The left ovary contained a small yellowish structure which proved to be an old corpus luteum on histologic examination. The cysts were lined partly by healthy appearing granulosa cells, partly by granulosa cells showing karyorrhexis, and partly by theca interna cells. The cortical zone contained numer-

---

* Read before the Section on Pathology and Bacteriology, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

From the Department of Pathology, Stanford University School of Medicine, San Francisco.

ous primordial follicles and a small number of developing Graafian follicles. The predominant cell type in the anterior hypophysis was the granulated acidophil interspersed with small groups of granulated basophiles. The basophiles were somewhat more numerous at the periphery of the hypophysis.

COMMENT

This case demonstrates several features which permit the diagnosis of the anovulatory cycle. The patient falls in the age group in which this type of menstrual cycle supposedly is rather frequent, the menarche having been four months and one week prior to death. The history of regularly spaced menstrual periods and the finding of only one corpus luteum indicates that three out of the four periods occurred without preceding ovulation and that ovulatory and anovulatory cycles may follow in succession. In the absence of any pelvic pathology, including evidence of hyperplasia of the endometrium which is more common in the older age group,[12] it seems safe to assume that our patient had regularly recurrent hemorrhages from a healthy uterus without ovulation and corpus luteum formation.

2202 California Street.

REFERENCES

1. Corner, G. W. Contribut. to Embryology Vol. 15, No. 75, 1923.
2. Corner, G. W. J.A.M.A. 89:1838, 1927.
3. Hartman, C. G. Anat. Record 35:abtr.26, p. 13, 1927.
4. Allen, Edgar Contribut. to Embroyology Vol. 19, No. 98, 1927.
5. Hartman, C. G. Contribut. to Embryology Vol. 23, No. 134, 1932.
6. Hartman, C. G. Western J. of Surgery, 52:139, 1944.
7. Markee, J. E. Contribut. to Embryology Vol. 28, No. 177, 1940.
8. Bartelmez, G. W. Contribut. to Embryology Vol. 24, No. 142, 1933.
9. Mazer, C. and Ziserman, A. J. Am. J. Surg. 18:332, 1932.
10. Novak, E. Amer. J. Obs. & Gyn. 37:605, 1939.
11. Hamblen, E. C. Endocrine Gynecology. Charles C. Thomas, Springfield, Ill., 1939.
12. Fluhmann, C. F. Menstrual Disorders. W. B. Saunders Comp. Philadelphia and London, 1939.

INTROSPECTION AND THE ORBITAL CORTEX*

J. M. Nielsen, M. D.
Los Angeles

As the subject of cerebral cortical localization of function develops, each few years' innovations show new obstacles falling before the attacks of students. As would be expected, those functions which most definitely have appeared to be psychological have been the last to be physiologically understood. It now has become established that the orbital cortex, chiefly areas 11 and 12 of Brodmann, contains the neurograms of the cortical representative of personality, character and introspection—in short, patterns of the "self."

The entire neurogram system of personality and self is constituted of a hypothalamic, a thalamic and two cortical portions, a cingulate and an orbital component. In the lower animals there is no orbital fraction and the animals show practically no cortical modification of the instinctive personality. The anthropoids do have some orbital cortex but it is relatively rudimentary. Animals in general are spontaneous; they live for the moment; they do not show any signs of introspection and are apparently unconcerned with their origin or destiny. It would be both interesting and instructive, in fact of clinical value, if one could determine what cortical structure and what corresponding cerebral function distinguish man from animals.

* Read before the Section on Neuropsychiatry, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

The researches of von Bonin[1] and of others doing cytoarchitectonic work have shown during the last few years that primates have areas of Broca which are well developed. In harmony with this, but as an entirely independent observation, Sanderson[2] has found that the gorilla in his natural haunts has "as many speech sounds and combinations as man." We are therefore compelled to conclude that speech is not entirely a human capacity.

COMPARISON OF HUMAN AND PRIMATE BRAINS

Comparison of human and primate brains shows clearly that the great difference in the cortex, as one ascends the scale, is in the size of the frontal lobes. Man has far more frontal cortex, even in proportion to total brain volume, than has the gorilla. Such an observation, however, proves nothing unless the situation is more clearly analyzed.

Analysis reveals that the gorilla has areas 6, 8, 9, 10, 44 and 47 in about as large a proportion for its brain as the human being possesses. These areas are concerned with movements, coördination and speech. But the orbital cortex, which is apparently concerned only with self, the relation of the individual to the environment, with introspection and personality, is particularly small in the gorilla and still smaller in the orangutan and chimpanzee. And it is exactly in these respects that man is superior. Comparison of gorilla brains with human brains in lateral silhouette shows the average human to be superior to that of the gorilla brain, but such a simple comparison is fallacious. The entire gorilla brain weighs less than half the average human brain. (Not more than 100 gorilla brains have been studied and it is quite possible that much larger ones do occur, but large human brains also are known.) The final correlation would have to be made by cytoarchitectonic comparisons. The general impression of such an authority as Tilney[3] is that the human brain is far superior.

Another criterion commonly used but exceedingly fallacious (in the sphere of function) is that of knowledge of paternity. All students are agreed that animals do not possess such knowledge; the male gorilla certainly does not know, or suspect, that he fathers the young. However, the lowest forms of human being also lack knowledge of paternity. Malinowski[4] has shown for the Trobriand Islanders and Daisy Bates[5] for the Australian aborigines that they do not know, and cannot be convinced, that children result from coitus. They believe that spirits cause pregnancy and that coitus is exclusively for pleasure. Some human beings, therefore, are not above the gorilla in such knowledge, but they are far superior in having thought about it and in having arrived at a belief which satisfies them.

SYNDROME OF THE ORBITAL CORTEX

There are in the literature about a dozen cases of accidental destruction of both orbital cortices in the adult human being. These cases show a typical syndrome which should enable the physician to establish the diagnosis. Case reports can be found in the large work of Kleist.[6] When the lesion is unilateral the matter is very uncertain because of the ability of the remaining cortex to carry on. Patients with bilateral lesions show character changes the basic element of which is the loss of self critique. But more fundamental than self critique is introspection, because one does not criticize what one does not inspect. The patients accept no discipline and if it is forced upon them they do not profit by it. They have no consideration for others, no self respect. As they have no self respect they have no pride and are not easily insulted. Kind advice has no lasting result. The patients characteristically lie and steal and have violent outbursts.

This syndrome has some resemblance to that of tumors

of the third ventricle. But lesions of that site, which affect the hypothalamus and thalamus, cause their syndrome by affecting the basilar end of the neuronal system underlying personality. Hence the cortical elements are unaltered and the syndrome is different. The patients are forgetful and somewhat stupid. However, in any syndrome suggesting orbital cortex lesion it is well to exclude neoplasm of the third ventricle.

SUMMARY

The arbital cortex and its connections with the diencephalon are much more highly developed in man than in the primates. Its proportionately much greater volume means something in this connection but size alone does not give a crucial answer. It is the far more highly developed organization of this area which distinguishes man from animals. A clinical syndrome is outlined which makes recognition of a lesion of the orbital cortex possible. The keynote of the syndrome is loss of capacity for introspection.

727 West Seventh Street.

REFERENCES

1. von Bonin, G.: Architecture of the Precentral Motor Cortex and some Adjacent areas, In Bucy, the Precentral Motor Cortex, Univ. of Illinois Press, Urbana, 1944.
2. Sanderson, I. T.: Animal Treasure, Viking Press, New York, 1937.
3. Tilney, F.: The Brain from Ape to Man, Paul B. Heober, New York, 1928.
4. Malinowski, B.: The Sexual Life of Savages, Horace Liveright, New York, 1929.
5. Bates, Daisy: The Passing of the aborigines, Murray, London, 1938.
6. Kleist, K.: Gehirnpathologie, Barth, Leipzig, 1934.

PRESIDENT HARRY S. TRUMAN'S FEDERAL HEALTH INSURANCE PLAN*

Washington, Nov. 19.—(AP.)—President Truman's message to Congress on a national health program follows, in part:

(A)—In my message to the Congress of September 6, 1945, there were enumerated in a proposed economic bill of rights certain rights which ought to be assured to every American citizen.

One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears of . . . sickness."

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have the protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

(B)—The people of the United States received a shock when the medical examinations conducted by the selective service system revealed the widespread physical and mental incapacity among the young people of our nation. . . .

We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently in terms which all of us can understand.

DRAFT RECORD

As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 per cent of all those examined. The percentage of rejection was lower in the younger age groups and higher in the higher age groups, reaching as high as 49 per cent for registrants between the ages of 34 and 37.

In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the armed forces for diseases or defects which existed before induction.

(C)—Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives. . . .

It is not so important to search the past in order to fix the blame for these conditions. It is more important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age.

Medicine has made great strides in this generation, especially during the last four years. We owe much to the skill and devotion of the medical profession. In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.

We are proud of past reductions in our death rates. But these reductions have come principally from public health and other community services. We have been less effective in making available to all of our people the benefits of medical progress in the care and treatment of individuals.

MANY DEPRIVED

(D)—In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future—unless government is bold enough to do something about it.

People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities.

Our new economic bill of rights should mean health security for all, regardless of residence, station, or race —everywhere in the United States.

(E)—We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.

FIVE PROBLEMS

There are five basic problems which we must attack vigorously if we would reach the health objectives of our economic bill of rights.

(F)—I—The first has to do with the number and distribution of doctors and hospitals. One of the most im-

* For convenience of readers of CALIFORNIA AND WESTERN MEDICINE, when referring to the almost complete text of the message on a National Health Program submitted to the 79th Congress by Harry S. Truman, President of the United States, the text as here appearing has been marked by letter reference in brackets and with arrows. Additional paragraphs and paragraph lettering have also been inserted.

For editorial comment in current issue of CALIFORNIA AND WESTERN MEDICINE, see pages 259-264.

portant requirements for adequate health service is professional personnel—doctors, dentists, public health and hospital administrators, nurses and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing. Indeed, in 1940, there were thirty-one counties in the United States, each with more than a thousand inhabitants, in which there was not a single practicing physician. The situation with respect to dentists was even worse.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason—closely allied with the first—is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

* * *

(G)—The demobilization of 60,000 doctors, and of the tens of thousands of other professional personnel in the armed forces is now proceeding on a large scale.

SPEED NEEDED

Unfortunately, unless we act rapidly, we may expect to see them concentrate in the places with great financial resources and avoid other places, making the inequalities even greater than before the war.

Demobilized doctors cannot be assigned. They must be attracted. In order to be attracted, they must be able to see ahead of them professional opportunities and economic assurances.

* * *

(H)—Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics and health centers to take proper care of the people of the United States.

About 1,200 counties, 40 per cent of the total in the country, with some 15,000,000 people, have either no local hospital or none that meets even the minimum standards of national professional associations. The deficiencies are especially severe in rural and semirural areas and in those cities where changes in population have placed great strains on community facilities. I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

* * *

(I)—II—The second basic problem is the need for development of public health services and maternal and child care.

The Congress can be justifiably proud of its share in making recent accomplishments possible. Public health and maternal and child health programs already have made important contributions to national health. But large needs remain. Great areas of our country are still without these services. This is especially true among our rural areas; but it is true also in far too many urban communities.

Although local public health departments are now maintained by some 18,000 counties and other local units, many of these have only skeleton organizations, and approximately 40,000,000 citizens of the United States still live in communities lacking full time local public health service. At the recent rate of progress in developing such service, it would take more than a hundred years to cover the whole nation.

If we agree that the national health must be improved, our cities, towns and farming communities must be made healthful places in which to live through provision of safe water systems, sewage disposal plants and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children and innoculation for the prevention of communicable diseases are accepted public health functions. So, too, are many kinds of personal services such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population lacks many or all of these services.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. Typhoid fever, smallpox and diphtheria—diseases for which there are effective controls—have become comparatively rare. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, malaria and other major threats to life and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.

* * *

(J)—III—The third basic problem concerns medical research and professional education. . . .

RESEARCH AND EDUCATION

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

URGES RESEARCH

Research—well directed and continuously supported—can do much to develop ways to reduce those diseases of body and mind which now cause most sickness, disability, and premature death—diseases of the heart, kidneys and arteries, rheumatism, cancer, diseases of childbirth, infancy and childhood, respiratory diseases and tuberculosis. And research can do much toward teaching us how to keep well and how to prolong healthy human life.

Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year and should receive special attention. Though we already have the National Cancer Institute of the Public Health Service, we need still more coördinated research on the cause, prevention and cure of this disease. We need more financial support for research and to establish special clinics and hospitals for diagnosis and treatment of the disease, especially in its early stages. We need to train more physicians for the highly specialized services so essential for effective control of cancer.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses.

Accurate statistics are lacking, but there is no doubt that there are at least two million persons in the United States who are mentally ill and that as many as ten million will probably need hospitalization for mental illness for some period in the course of their lifetime. A great many of these persons would be helped by proper care. Mental cases occupy more than one-half of the hospital beds at a cost of about 500 million dollars per year, practically all of it coming out of taxpayers' money. Each year there are 125,000 new mental cases admitted to institutions. We need more mental disease hospitals, more

outpatient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental breakdown. Also we must have many more trained and qualified doctors in this field.

It is clear that we have not done enough in peacetime for medical research and education in view of our enormous resources and our national interest in health progress. The money invested in research pays enormous dividends. If any one doubts this, let him think of penicillin, plasma, DDT powder and new rehabilitation techniques.

* * *

(K)—IV—The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

COST OF MEDICAL CARE

In the aggregate all health services—from public health agencies, physicians, hospitals, dentists, nurses and laboratories—absorb only about 4 per cent of the national income. We can afford to spend more for health. But 4 per cent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs and not average costs. They may be hit by sickness that calls for many times the average cost—in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

For some persons with very low income or no income at all, we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons, however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.

Each of us know doctors who work through endless days and nights, never expecting to be paid for their services because many of their patients are unable to pay. Often the physician spends not only his time and effort, but even part of the fees he has collected from patients able to pay, in order to buy medical supplies for those who cannot afford them.

I am sure there are thousands of such physicians throughout our country. They cannot, and should not, be expected to carry so heavy a load.

* * *

FIFTH PROBLEM

(L)—V—The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

On an average day there are about 7 million persons so disabled by sickness or injury that they cannot go about their usual tasks. Of these, about 3¼ millions are persons who, if they were not disabled, would be working or seeking employment. More than one-half of these disabled workers have already been disabled for six months; many of them will continue to be disabled for years, and some for the remainder of their lives. Every year four or five hundred million working days are lost from productive employment because of illness and accident among those working or looking for work—about forty times the number of days lost because of strikes on the average during the ten years before the war. About nine-tenths of this enormous loss is due to illness and accident that is not directly connected with employment and is therefore not covered by workmen's compensation laws.

These, then, are the five important problems which must be solved if we hope to attain our objective of adequate medical care, good health and protection from the economic fears of sickness and disability.

* * *

(M)—To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts—each of which contributes to all the others.

* * *

FIRST: CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

(N)—The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers and other medical, health, and rehabilitation facilities. With the help of Federal funds it should be possible to meet deficiencies in hospital and health facilities so that modern services—for both prevention and cure—can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed but also to enlarge or modernize those we now have.

* * *

(O)—In carrying out this program there should be a clear division of responsibilities between the states and the Federal Government. The states, localities and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation and should make sure that Federal funds are allocated in those areas and projects where Federal aid is needed most. In approving state plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members. Adequate emphasis should be given to facilities that are particularly useful for prevention of diseases—mental as well as physcial—and to the coördination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans. The general policy of Federal-state partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

SECOND: EXPANSION OF PUBLIC HEALTH, MATERNAL AND CHILD HEALTH SERVICES

Our programs for public health and related services should be enlarged and strengthened. The present Federal-state coöperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child health services, and services for crippled children. These programs were especially developed in the ten years before the war and have been extended in some areas during the war. They have already made important contributions to national health, but they have not yet reached a large proportion of our rural areas, and in many cities they are only partially developed.

No area in the nation should continue to be without the services of a full time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services such as maternal and child health care.

Hospitals, clinics and health centers must be built to meet the needs of the total population and must make

adequate provision for the safe birth of every baby, and for the health protection of infants and children.

Present laws relating to general public health, and to maternal and child health, have built a solid foundation of federal coöperation with the states in administering community health services. The emergency maternity and infant care program for the wives and infants of servicemen—a great wartime service authorized by the Congress—has materially increased the experience of every state health agency and has provided much needed care. So too have other wartime programs such as venereal disease control, industrial hygiene, malaria control, tuberculosis control and other services offered in war essential communities. The Federal Government should coöperate by more generous grants to the states than are provided under present laws for public health services and for maternal and child health care. The program should continue to be partly financed by the states themselves and should be administered by the states. Federal grants should be in proportion to state and local expenditures and should also vary in accordance with the financial ability of the respective states.

The health of American children, like their education, should be recognized as a definite public responsibility. In the conquest of many diseases prevention is even more important than cure. A well rounded national health program should therefore include systematic and widespread health and physician education and examinations, beginnnig with the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should therefore see to it that our health programs are pushed most vigorously with the youngest section of the population. Of course, federal aid for community health services—for general public health and for mothers and children—should complement and not duplicate prepaid medical services for individuals, proposed by the fourth recommendation of this message.

THIRD: MEDICAL EDUCATION AND RESEARCH

(P)—The Federal Government should undertake a broad program to strengthen professional education in medical and related fields, and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to nonprofit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and nonprofit private agencies.

In my message to the Congress of Sept. 6, 1945 I made various recommendations for a general federal research program. Medical research, dealing with the broad fields of physical and mental illnesses, should be made effective in part through that general program and in part through specific provisions within the scope of a national health program. Federal aid to promote and support research in medicine, public health and allied fields is an essential part of a general research program to be administered by a central Federal research agency. Federal aid for medical research and education is also an essential part of any national health program if it is to meet its responsibilities for high grade medical services and for continuing progress. Coördination of the two programs is obviously necessary to assure efficient use of Federal funds. Legislation covering medical research in a national health program should provide for such coördination.

FOURTH: PREPAYMENT OF MEDICAL COSTS

(Q)—Everyone should have ready access to all necessary medical, hospital, and related services.

(R)—I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk and to benefit the insured who actually suffers the loss. If, instead of the costs of sickness being paid only by those who get sick, all people—sick and well—were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening any one. That is the principle on which all forms of insurance are based.

During the past fifteen years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3 per cent or 4 per cent of our population now have insurance providing comprehensive medical care. A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist and laboratory services, as needed, would also become available to all and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself as well as against medical bills.

(S)—Such a system of prepayment should cover medical, hospital, nursing and laboratory services. It should also cover dental care as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund instead of paying sporadically and unevenly when they are sick.

This health fund should be built up nationally in order to establish the broadest and most stable basis for spreading the costs of illness and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on state by state action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross state boundary lines.

Medical services are personal. Therefore the nationwide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical profession are represented.

* * *

(T)—Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate, and should be appropriately adjusted upward for those who are qualified specialists.

* * *

(U)—People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs.

* * *

(V)—People will remain free to obtain any medical service outside of the health insurance system if they

desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

(W)—Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health insurance system full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

(X)—Our voluntary hospitals and our city, county and state general hospitals, in the same way, must be free to participate in the system of whatever extent they wish. In any case they must continue to retain their administrative independence.

VOLUNTARY ORGANIZATIONS

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary coöperative organizations concerned with paying doctors, hospitals or others for health services, but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine."

(Y)—I repeat—what I am recommending is not socialized medicine.

Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed. Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all important difference: Whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

(Z)—I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, government employees and employees of nonprofit institutions and their families.

(Aa)—In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public assistance programs to reimburse the states for part of such premiums, as well as for direct expenditures made by the states in paying for medical services provided by doctors, hospitals and other agencies to needy persons.

(Bb)—Premiums for present social insurance benefits are calculated on the first $3,000 of earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount, such as $3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4 per cent of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide. The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists and nurses for the services they render. Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a nation-wide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals. We are a rich nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

COMPREHENSIVE HEALTH PROGRAM

(Cc)—Fifth—Protection against loss of wages from sickness and disability. What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the nation and providing an efficient and less burdensome system of paying for them. But no matter what we do, sickness will of course come to many. Sickness brings with it loss of wages. Therefore, as a fifth element of a comprehensive health program, the workers of the nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and long term disability. This protection can be readily and conveniently provided through expansion of our present social insurance system, with appropriate adjustment of premiums.

Insurance against loss of wages from sickness and disability deals with cash benefits, rather than with services. It has to be coördinated with the other cash benefits under existing social insurance systems. Such coördination should be effected when other social security measures are re-examined. I shall bring this subject again to the attention of the Congress in a separate message on social security.

I strongly urge that the Congress give careful consideration to this program of health legislation now.

Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it too.

By preventing illness, by assuring access to needed community and personal health services, by promoting medical research and by protecting our people against the loss caused by sickness we shall strengthen our national health, our national defense and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

We need to do this especially at this time because of the return to civilian life of many doctors, dentists and nurses, particularly young men and women.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.

EARLY PUBLIC HEALTH IN CALIFORNIA*

N. K. FOSTER, M.D., STATE HEALTH OFFICER, 1904-1910
BUBONIC PLAGUE OUTBREAK, 1900-1905

GUY P. JONES
San Francisco

WHEN Dr. N. K. Foster of Oakland became Secretary of the California State Board of Health in 1903 he found the State health organization at its ebb. Dr. George C. Pardee of Oakland, upon his election as Governor, had appointed Dr. Foster as secretary of the board.

Doctor Newel Kelly Foster was born in Centerbury, New Hampshire, on April 10, 1849. In college he graduated from the newly established Cornell University in 1873. Other collegiate work was taken at the University of Michigan, after which he entered Long Island College Hospital, receiving his M.D. degree as a member of the class of 1878. For several years he practiced medicine in Varna, New York, and in Laramie, Wyoming, then moving to Oakland where he practiced through the years 1886 to 1904. In 1904 he became Secretary of the California State Board of Health, acting in that capacity through 1910. From 1910 to 1920 he was Director of Health Development and Sanitation in the Oakland Public Schools. His death took place on September 9, 1926.

The members of the California State Board of Health during the period 1904 to 1910, at which time Doctor N. K. Foster was Secretary, consisted of the following: Martin Regensburger, San Francisco, President; N. K. Foster, Sacramento, Secretary; F. K. Ainsworth, San Francisco; W. A. Briggs, Sacramento; A. C. Hart, Sacramento; O. Stansbury, Chico; W. Le Moyne Wills, Los Angeles.

CALIFORNIA BUBONIC PLAGUE OUTBREAK OF 1900-1904

In addressing the health officers of California at their annual meeting held at Stanford University in 1922, Dr. Foster gave the following interesting account of his experiences upon entering the State office:

"If I were limited to one word in stating the necessity of a State health organization, I should without hesitation say, *Plague,* for in many ways the breaking out of that disease focused attention on our lax health organization and made imperative a radical improvement, or have California cut off by quarantine from communication with other States.

"Plague was first recognized in San Francisco in March, 1900, and of course caused a great deal of comment. Many strongly believed that it did not and could not exist. The State Board of Health, however, admitted its existence. Many leading newspapers and public men thought otherwise—and believed that even if it did exist any publicity would hurt the State. They strenuously denied its existence and the State Board of Health was induced, or did reverse itself and also declared the disease was not plague. This aroused the ire of eastern health officers and exaggerated stories were published there of its ravages—people were dropping dead on the streets, it was said. They were so wrought up that the health authorities of 21 States requested Surgeon-General Walter Wyman to call a conference of the State Board of Health with the U. S. Public Health and Marine Hospital Service for the purpose of dealing with the situation. The conference was called and met in January, 1903. California was represented by Dr. Mathew Gardner—a member of our State Board of Health. He was given a very unhappy half hour by the thoroughly angered and possibly frightened health officers—and a quarantine resolution against California was introduced. Through the influence of General Wyman it was left as unfinished business for a conference to be called later.

"Meanwhile things were doing in California. During the years 1900, 1901, 1902, 1903, there had been 110 cases of plague authenticated with 105 deaths and some people were beginning to be alarmed.

"At the general election Dr. Geo. C. Pardee was elected Governor and at once interested himself in the situation. The California State Board of Health is organized by the Governor nominating the members and the Senate ratifying the nominations. Governor Gage had nominated the board that denied the existence of plague but the Senate had neglected to ratify—so they were acting only at the pleasure of the Governor. Governor Pardee, feeling deeply the gravity of the situation, with a quarantine hanging over us—withdrew the nomination and appointed a new board with the exception of Dr. Mathew Gardner. He, however, died in two weeks and we were deprived of his splendid ability. This was in February or March, 1903. On April 1st the new board met with the old and after the old had closed up their business—the new one organized and I had the honor to be elected Secretary and Executive Officer.

STATE DEPARTMENT OF PUBLIC HEALTH EQUIPMENT IN 1903

"After adjournment, I called on my predecessor, who had his desk in the office of the State Lunacy Commission, and asked for the property of the board. With a quizzical look he said, 'Property of the board, it has no property. That desk is mine and every scrap of paper in it.' He did, however, give me a bunch of letter heads and pointing to the bay window said, 'Those old reports of other State boards are at your disposal.' He sat between his desk and the steel safe, made famous by the sarcastic remarks of Carrie Nation as she 'hatchetted her way through the State, and said, 'Sit down and I'll give you some advice.' I was receptive, thinking to get some pointers on the work. Instead, 'You have a good practice, stay with it, have some one open your mail and attend to it, come once a month and draw your pay and show yourself, and let me show you how to make out your expense account for the trip. He proceded to put down items, some of which I had, some not, dinner $5 and everything in proportion. I said, 'But Doctor, it didn't cost that much.' 'Oh! that doesn't matter, you have $1,500 a year to spend on the expenses of the board and you have to get rid of it. You might as well have it as anybody.'

"Not a bright outlook and I went to my room in none too happy a mood. No desk—no chair and no place to put them if I had.

"Next morning, I interviewed Mr. Mellick, Secretary of the State Board of Examiners. He had large offices, but personally he was using, during the interim of the legislative session, the Lieutenant Governor's room. He kindly let me have desk room there also. The janitor rustled me a desk and chair and I turned to the pile of old State reports. With them, I found many unopened letters and this gave me a start to work. Some were months old and some had in them stamps to insure a reply. I didn't blame one doctor, who was acting as best he could as health officer in his village, for using some pretty powerful language. He said, 'This is the third time I have written and have no reply and by ——— it is the last.' I replied that a new deal was ordered and that in future he would get some sort of a reply by return mail.

"Do you blame me for feeling lonely and blue? I had

---

*From the California State Department of Public Health.

Guy P. Jones, author of the above article, for many years edited the Bulletin of the California State Board of Public Health. During the last year, he has retired from State work and is now living in Guadalajara, Mexico.

given up my practice and broken up my home believing I was to fill, or try to fill, an office of honor—and I found nothing but disgrace abroad and contempt at home—and right there the seed of this association was planted.

"The need of work and organized work was forced on me in those hours of discouragement. I saw the futility of my working without the aid and coöperation of others throughout the State. An account of the June 3rd Plague conference in Washington where we fought it out and instead of a quarantine got a resolution of confidence has no place here.

STATE HEALTH DIRECTOR FOSTER'S EARLY TASKS

"It was a busy spring and summer I spent trying to arouse interest in public health matters. I attended all the medical societies I could, visited the different health officers and answered all calls for help in person. I met with willingness everywhere but a good deal of incredulity that the State Board of Health was anything but a political sinecure and it seemed to me they all came from Missouri and had to be shown. Very well, I determined to show them.

"From the nature of things, the executive officer of the board at that time had most of the work to do, there were no assistants, not even a stenographer, but never was such officer backed up by a better board. Throughout the six years we were together, there was never a jar in the organizatoin and they always stood behind me. The Governor also was always ready to help to the limit. Things began to move but the need of organization was always making itself felt. There were no laws and it was everyone for himself." . . .

REHABILITATION OF CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

To Dr. Foster must be given full credit for the organization of the California State Department of Public Health along modern standard lines. It was he who secured legislation in 1905 and 1907 to provide for the organization of the Bureau of Vital Statistics, Bureau of Pure Foods and Drugs, and the State Hygienic Laboratory. Actually during the period that Dr. Foster served, from 1903 to 1909, he secured the passage of fundamental legislation that has established the pattern upon which the present State public health organization is built. At the same time he conducted, by himself, a Statewide epidemiological service.

Although not in vigorous health, he answered emergency calls from one end of the State to another, giving advice on the control of and assisting in the diagnosis of typhoid fever, smallpox, plague, diphtheria, and many other communicable diseases. In those days typhoid fever was a common disease and smallpox was rampant throughout the State.

He accomplished more in the six years that he served as health officer than any of his immediate predecessors. He had a thorough and deep knowledge of public health and put up a continuous fight for legislative action that would provide efficient facilities for the promotion and maintenance of public health in California. The bureaus that he established during his tenure of office have been functioning continuously since that time and have established their essential offices in the maintenance of public health. Others, of course, were established at various intervals.

It has been stated that Dr. Thomas M. Logan, the first secretary of the California State Board of Health, was the George Washington of public health in California, and that Dr. N. K. Foster was the Abraham Lincoln of public health in this State. There is considerable realism in this allusion for when Doctor Foster assumed office there was virtually no State public health organization in California. It was only through his knowledge, energy, enthusiasm, and ability to secure proper legislation that the California State Board of Health was established definitely as a distinct unit in the State government.

The development of the organization since that time is a matter of record. To Dr. Foster, public health workers of California owe a deep debt of gratitude, for without his foresight it is doubtful that public health in California would be established upon the high plane that prevails at this time.

Through Dr. Harry E. Foster of the Cutter Laboratories in Berkeley, his father's diary has been made available to the writer. The daily record of disappointment, heartbreaking work, overcoming of difficulties, and remarkable accomplishments makes thrilling reading. That one man could successfully carry on the whole State public health work by himself over a period of years and then leave an organization of dependable units to establish and carry on modern standard public health service is a remarkable accomplishment for shortly after the turn of the century.

668 Phelan Building, 760 Market Street.

$375 Million Health Bill Up

Washington, Oct. 24.—Congress was asked today to put up 375 million dollars toward construction of hospitals and health centers during the next five years.

Nearly 50 per cent of the money would go to Southern states.

The Senate education and labor committee, in line with President Truman's request for legislation authorizing Federal aid toward hospital construction, has approved a measure which would:

1. Provide for Federal grants of 75 million dollars a year for five years beginning with fiscal 1947. The Government's contribution would range from 33 1/3 per cent in the richest states to 75 per cent in the poorest.

3. Authorize immediate expenditure of five million dollars to pay half the cost of surveys of hospitals and health centers needed in each state.

3. Create a special Federal hospital council through which state building plans would be cleared.

Senator Lister Hill (D., Ala.), sponsor of the measure, said he expects to call it up for Senate action next week. —San Francisco *News*, October 24.

Explore the Details First

Probably one of the reasons why Congress has been slow to include compulsory health insurance legislation such as proposed in the Wagner-Dingell Bill as part of the Federal social security program, is the problem of cost in proportion to benefits. The Wagner-Dingell Bill specifically provides that social security payroll taxes be raised to a total of eight per cent, half to be paid by the employer and half by the employee. Of the eight per cent, four per cent is intended to defray the expense of medical care, hospitalization, and temporary disability. Thus the wages of a person earning $225 per month would be subject to a total social security tax of $216 annually, half of which would be deducted directly from the salary check. One-hundred-and-eight dollars of the $216 would be for medical and temporary disability protection.

How does this compare with the cost of accident, health and hospitalization insurance in government-regulated insurance companies in group form?

Here is what can be purchased for $39 per year: $30 weekly benefits for illness and accident, $5 daily hospital benefit for a 70-day period, plus $25 for laboratory medicines, x-ray and other charges, plus up to $150 reimbursement for surgical expenses. Hospital benefits are paid for 70 days just as many times in a year as the employee may need them. Also, when a contract is purchased from a private company, it cannot be changed by the insurance company as long as payments are made. Any government insurance plan may be changed at the will of Congress. These are but a few of the details that should be explored before the country goes overboard for state medicine.—Bloomington *News*, October 12.

America is God's Crucible, the great Melting-Pot where all the races of Europe are melting and re-forming! . . . God is making the American.

—Israel Zangwill, *The Melting-Pot*, Act 1. Produced in New York City, Oct., 1908.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

PHILIP K. GILMAN, M.D.....President.
SAM J. McCLENDON, M.D.....President-Elect
E. VINCENT ASKEY, M.D.....Speaker
LEWIS A. ALESEN, M.D.....Vice-Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
JOHN W. CLINE, M.D...Chairman, Executive Committee
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON .....Executive Secretary

EDITORIAL BOARD

Chairman of the Board:
Albert J. Scholl, Los Angeles

Executive Committee:
Lambert B. Coblentz, San Francisco
H. J. Templeton, Oakland
Albert J. Scholl, Los Angeles
George W. Walker, Fresno

Anesthesiology:
William B. Neff, San Francisco
Roscoe C. Olmsted, Pasadena

Dermatology and Syphilology:
William H. Goeckerman, Los Angeles
H. J. Templeton, Oakland

Eye, Ear, Nose and Throat:
Frederick C. Cordes, San Francisco
Lawrence K. Gundrum, Los Angeles
George W. Walker, Fresno

General Medicine:
Lambert B. Coblentz, San Francisco
L. Dale Huffman, Hollywood
Mast Wolfson, Monterey

General Surgery (including Orthopedics):
Frederic C. Bost, San Francisco
Fred D. Heegler, Napa
William P. Kroger, Los Angeles

Industrial Medicine and Surgery:
John D. Gillis, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
William S. Kiskadden, Los Angeles
George W. Pierce, San Francisco

Neuropsychiatry:
Olga Bridgman, San Francisco
John B. Doyle, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, San Francisco
Donald G. Tollefson, Los Angeles

Pediatrics:
William W. Belford, San Diego
William C. Deamer, San Francisco

Pathology and Bacteriology:
Alvin G. Foord, Pasadena
R. J. Pickard, San Diego

Radiology:
R. R. Newell, San Francisco
John W. Crossan, Los Angeles

Urology:
Frank Hinman, San Francisco
Albert J. Scholl, Los Angeles

Pharmacology:
W. C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twenty-ninth (329th) Meeting of the Council of the California Medical Association

The meeting was called to order at 10:00 A.M., on Sunday, October 21, 1945, at the Hotel Biltmore, Los Angeles.

1. **Roll Call:**

Councilors Present: Philip K. Gilman, Chairman; E. Vincent Askey, Edwin L. Bruck, E. Earl Moody, Edward B. Dewey, Walter S. Cherry, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, and George H. Kress, Secretary.

Councilors Absent: Sam J. McClendon, Sidney J. Shipman, Dewey R. Powell (ill), R. Stanley Kneeshaw, and John W. Green.

Present by Invitation: C.M.A. Delegates to the A.M.A. Dwight L. Wilbur, Lowell S. Goin, Dwight H. Murray, H. Gordon MacLean, and Donald Cass; Alternate Delegate to the A.M.A. Leo J. Madsen; L. A. Alesen, Vice-Speaker; Harold A. Fletcher, Chairman of the C.M.A. Postwar Planning Committee; W. M. Bowman, for C.P.S.; Howard Hassard, Associate Legal Counsel; Ben H. Reed, Secretary, California Public Health League; W. Glenn Ebersole; E. T. Remmen, Chairman Local Committee on Arrangements for 1946 C.M.A. Annual Session; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; Fred W. Borden, Secretary, Santa Clara County Medical Society, and Chester L. Cooley, C.P.S. Secretary.

2. **Minutes:**

Minutes of the following meetings of the Council and Executive Committee were submitted and actions taken approved:

(a) Council Meeting (328th) held in San Francisco on August 12, 1945. (Printed in CALIFORNIA AND WESTERN MEDICINE, October, 1945, page 175.)

(b) Executive Committee Meeting (195th) held in San Francisco, September 26, 1945. (Printed in CALIFORNIA AND WESTERN MEDICINE, October, 1945, page 181.)

(c) Special Meeting of the "Members of 'Trustees of the California Medical Association'", (18th), held in San Francisco, on August 12, 1945.

3. **Membership:**

(a) A report of the membership as of October 15, 1945, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1945: 7,839.

Total members in military service: 2,229.

(b) On motion made and seconded, it was voted to reinstate 7 members whose 1945 dues had been paid subsequent to April 1, 1945.

(c) On motion made and seconded, Retired Member-

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

ship was granted to the following members, whose applications had been received in accredited form from their county societies:

Paul Campiche, San Francisco County
William Humes Roberts, Los Angeles County
W. Frank Holman, Los Angeles County
Donald J. Frick, Los Angeles County

(d) Association Secretary Kress referred to correspondence with A.M.A. Secretary West on whether Retired Members of the California Medical Association are eligible for A.M.A. Fellowship. Secretary West had written that the matter had been referred to the A.M.A. Judicial Council, but no opinion had been rendered by the A.M.A.

4. **Financial:**

(a) A cash report as of October 15, 1945, was submitted.

(b) Report was made concerning income and expenditures for September and Nine Months ending September 30, 1945.

(c) A balance sheet, as of September 30, 1945, was submitted.

On motion made and seconded, the above reports were received and placed on file.

5. **Interim Appointments:**

Council Chairman Gilman informed the Council that he had appointed the Local Committee on Arrangements for the 1946 Annual Session of the California Medical Association, as follows: E. T. Remmen, Los Angeles, Chairman; L. A. Alesen, Los Angeles; Louis J. Regan, Los Angeles; W. H. Geistweit, Jr., San Diego; Arthur E. Varden, San Bernardino; George H. Kress, San Francisco (ex-officio, through by-law provision); and Stanley Cochems, Los Angeles. The appointments were approved.

6. **Special Committee on Prepayment Plans and C.P.S.:**

Doctor Gilman made a progress report concerning the meetings of the Special Committee on Prepayment Plans and California Physicians' Service, of which committee Loren R. Chandler is chairman.

7. **C.M.A. Advisory Planning Committee:**

Mr. Hassard, reporting for the Advisory Planning Committee, presented the recommendations made at the third meeting of that committee, held on September 24th, as follows:

The chairman reported that at the last meeting of the Council there was referred to this committee for study and recommendation, a written proposal dated July 5, 1945, addressed to the California Medical Association by several of the insurance companies in California (the companies being Occidental Life Insurance Company, Pacific Employers Insurance Company, California-Western States Life Insurance Company, Federal Life Insurance Company, and the Associated Indemnity Company). The written proposal was then considered in detail. In substance, it requests the California Medical Association to approve a fee schedule to be included in all medical and surgical indemnity contracts, and to use its best efforts to require physicians to limit their charges to policy holders to the amount of the fee schedule, except where policy holder's income is over $4,000 per year. The proposal also suggested that all contracts issued with the California Medical Association's approved fee schedule be publicized under the name "California Plan."

After full discussion, it was unanimously decided to recommend to the Council as follows:

1. That the insurance companies be notified that the California Medical Association regrets that it is not feasible or practical for the California Medical Association to adopt or recommend to its members any schedule of fees for general application in the practice of medicine and surgery. (Council approved.)

2. That the California Medical Association inform the insurance companies that the medical profession is at all times alert to the matter of gross overcharging of patients, and that whenever evidence of gross overcharging is presented to the organized profession, it is most anxious to take all steps within its power to remedy such inequity as may exist; and that for such purpose the larger county medical societies have permanent Grievance Committees which, on proper complaint brought by a patient, can and will investigate claimed overcharges, and, if warranted, can and will institute disciplinary proceedings. Bearing in mind that a charge that is unwarranted in relation to the services rendered by any physician is a collective responsibility of the medical profession, it was further recommended that the Council officially call to the attention of all component county societies the fact that California insurance companies issuing medical or surgical indemnity policies have complained that a small percentage of doctors habitually overcharge, and urging each county medical society either to establish a Grievance Committee, if none now exists, or to request its existing Grievance Committee to use every effort to locate any instances of gross overcharging that may exist in the county, and take all steps possible to prevent repetition of overcharging. (Council approved.)

3. That the Council adopt a symbol or mark (e.g., a golden bear and the words "California Plan for Health Security") to be used by all bona fide reputable organizations in the voluntary health insurance field, and to be publicized throughout the State as a symbol of merit, with the purpose of thereby stimulating public interest in voluntary health insurance, and that the insurance companies be requested to join with the California Medical Association and California Physicians' Service and Blue Cross plans in promoting such a symbol or mark. (Council to pass on symbol to be adopted. Symbol to be owned by C.M.A. and copyrighted. Its use be permitted only by those insurance plans that meet the "Principles on Health Insurance" adopted by the Council at its August meeting.) (Council approved.)

4. That the Council propose to the insurance companies that a comprehensive plan be entered into under which California Physicians' Service and the Blue Cross organizations would cover medical, surgical and hospital services and care, the insurance companies would cover group life insurance and cash indemnity for loss of time during illness or injury, and under which the entire package would be sold to the public through the existing sales outlets of the insurance companies, such a plan to involve no sales commissions payable by California Physicians' Service or Blue Cross, except possibly a minimum commission to reimburse the insurance companies for their actual out-of-pocket costs. It was recommended that this plan be proposed, together with a publicity campaign founded upon an approved symbol, as a joint undertaking without any element of profit to anyone, in order that the maximum voluntary health insurance coverage can be obtained and the threat of compulsory health insurance thwarted. (Council approved.)

Mr. Reed then reported on the first public hearing conducted by the Assembly Interim Committee on Health Care at Los Angeles Friday, September 7, 1945: Doctor Askey and Mr. Cochems had appeared on behalf of the California Medical Association, and Mr. Von T. Ellsworth appeared for the Farm Bureau. Mr. Ellsworth complained bitterly about the supposed California Medical Association opposition to group practice. Assemblyman Collins suggested that the California Medical Association adopt a resolution clarifying its attitude on group

practice. The committee then decided to recommend that a letter be written to Assemblyman Collins pointing out that the California Medical Association's principles on health insurance covered the entire subject.

After discussion, it was unanimously decided to recommend that each of the District Councilors on the California Medical Association's Council invite all component society secretaries in their districts to attend meetings of the Council, as observers, (C.M.A. not to be responsible for travel expenses.) In this connection, Doctor Remmen pointed out that it was difficult for the county society secretaries to keep abreast of all events through correspondence, and that attendance at Council meetings would prove both informative and stimulating. (Council approved.)

The Advisory Planning Committee unanimously recommended that Mr. Frank J. Kihm, Executive Secretary of the San Francisco County Medical Society, be appointed by the Council a member of the committee. (Council approved.)

The recommendations made at the fourth meeting of the Advisory Planning Committee held on October 17th, as per report made by Mr. Ben Read, were approved as follows:

Mr. Read gave a progress report covering the Washington office maintained by the United Public Health League. The present situation with respect to the Wagner-Murray-Dingell Bill, the hospital construction bill, Veterans Administration legislation and other national matters were reported and discussed. It was decided to recommend to the Council that the medical profession in this State, through appropriate organizations, obtain in advance the views of every candidate for a State or National office at the next California general election in 1946, with respect to the subject of medical costs and their distribution and that those candidates whose publicly expressed views are in the public interest be wholeheartedly supported and those candidates whose views do not accord with the public interest be vigorously opposed.

8. **California Physicians' Service:**

Reports were made by C.P.S. Secretary Chester L. Cooley, and C.P.S. Director W. M. Bowman.

Doctor Cooley referred to the meeting of C.P.S. Trustees held on October 20th, and among items receiving comment were the following: Court suit now pending concerning certain legal phases; better understanding with commercial insurance carriers; status of the medical service rendered in housing areas, and that all housing medical service units except that in Vallejo had been closed; new fee schedules for C.P.S. professional members; Alameda County and Sacramento County problems, in relation to services rendered by professional members.

Discussion was participated in by Councilors Kindall, MacDonald and Cline, and on motion made and seconded, it was voted that the Council request the Sacramento Society for Medical Improvement to make possible a conference at a regular or special meeting, at which C.P.S. problems of mutual interest could be discussed.

Mr. Bowman, Director of C.P.S., referred to the following items: Prospective new groups who might come into C.P.S.; activities of the four speakers to service clubs whose salaries were paid through allocation from the C.M.A.; financial status of C.P.S., stating that in September, C.P.S. received $26,000 in excess of expenditures.

Other comment was made by Doctor Lowell S. Goin, President of the C.P.S. Trustees. Doctor Goin gave a break-down of payments received in his office from 100 C.P.S. chest patients as contrasted to payments received from 100 private chest patients; the income from the C.P.S. group was $3,762.00; and from the same number of private patients, $3,848.50.

Suggestion was made that it would be interesting if similar break-downs could be obtained from, say ten surgeons representing rural and urban areas, and ten specialists; the thought being expressed that such an analysis would demonstrate that the money actually received from C.P.S. patients is quite in line with the income that would be received from the same number of private patients.

Reference was also made to a letter of September 10th, received from Doctor James N. Neil of Oakland, concerning C.P.S. It was voted to send this letter to the Committee on Prepayment Plans and C.P.S., of which Doctor Chandler is chairman.

9. **Report of C.M.A. Committee on Postwar Plans for the Medical Profession:**

Doctor Harold A. Fletcher, Chairman of the C.M.A. Committee on Postwar Planning, and also Chairman of the California Procurement and Assignment Service for Physicians, submitted a report in which the conditions that had developed in California incident to the return of a large number of military colleagues from both California and other states, were taken up in detail.

The report dealt with the procedures designed to protect the rights of California colleagues who are still in military service, the plans in regard thereto to apply both to California and other state physicians who desire to reëstablish themselves in practice. Concerning California colleagues, it was felt that until conditions are more settled, all such colleagues should go back to their former places of practice, rather than reëstablish themselves in some other California community.

It was stated there is no legal power to prevent a man from establishing himself wherever he desires. However, the State and County Procurement and Assignment Services for Physicians were agreed that they would not construe a returning physician "essential for civilian practice" in any particular community, if physicians who formerly practiced in that community were still in military service, and the community was not in need of additional physicians. Every case is to be treated as an individual proposition, and in accordance with the needs of the community.

(The full report by State Procurement and Assignment Service Chairman Fletcher appears in CALIFORNIA AND WESTERN MEDICINE for November, on page 228. Editorial comment in regard thereto appears in the same issue on page 205. A letter outlining the procedure adopted by the Santa Clara County Procurement and Assignment Service, submitted by Doctor Fred W. Borden, Chairman, appears on page 229 of the November issue of CALIFORNIA AND WESTERN MEDICINE.)

After full discussion, the Council voted to approve the recommendations made by the P. & A. Service, and that steps be taken to acquaint the component county medical societies and the A.M.A. with the recommendations made therein.

Doctor Fletcher suggested that Editor Kress also make editorial mention in regard to the report.

10. **A.M.A. in San Francisco in 1946:**

Association Secretary Kress stated a telegram had been received from A.M.A. Secretary West, stating that if transportation and meeting facilities are available in San Francisco in 1946, the Annual Session of the American Medical Association previously scheduled for San Francisco in that year, if held, might not take place until July or August, 1946.

Mention was made of the activities of the San Francisco Convention Bureau, whose Director, Mr. Walter G. Swanson, in conjunction with C.M.A. Officers, is carrying on the negotiations for meeting facilities in the Civic Center.

It was stated that decision concerning the date of the 1946 A.M.A. meeting might be made by the Trustees and

the House of Delgeates of the A.M.A. at the meeting to be held in Chicago on December 3-6, 1945.

11. **Annual Dues for 1946:**

(a) The Council discussed the dues of members returning from military service, with special reference to period of time a waiver of dues should continue after military colleagues had returned to civilian status.

After consideration by a sub-committee, consisting of Doctors Cline, MacDonald, and Askey, the following resolution was presented and approved by the Council:

WHEREAS, Returning military members of the California Medical Association have been and are under disruption of their economic status by factors beyond their control; and

WHEREAS, Payment of dues during the period of time of recent discharge from the service might work a hardship on them; therefore be it

Resolved, That military leave (for service in the Armed Forces) be considered as in force until January 1, 1947, for all those who have been granted such military leave of absence; and be it further

Resolved, That the Council of the California Medical Association recommend to the House of Delegates at the next session to consider what is its wish in regard to those members who are still in service after January 1, 1947.

(This would eliminate payment of the $100.00 dues by any military member and would postpone until January 1, 1947 (1½ years) the payment of any dues except as specifically ordered by the House of Delegates after considering all angles of the problem.)

(b) Doctor Gilman called attention to letters that had been received concerning the 1946 dues that were adopted by the C.M.A. House of Delegates in May, 1945. Attention was called to the fact that the Council has no authority in the matter, since the action had been taken by the supreme body of the Association; namely, the C.M.A. House of Delegates.

12. **Annual Session of California Medical Association in 1946:**

Chairman of the Committee on Scientific Work, Doctor Kress, placed before the Council some queries concerning next year's Annual Session, regarding dates, number of days of meeting, and place of meeting.

The 1945 House of Delegates having voted that the 1946 Annual Session should be held in Los Angeles, the Council heard reports concerning hotel facilities and agreed that the Hotel Biltmore would be the preferable place of meeting, particularly since it would be possible also to make arrangements for commercial exhibits.

Also, since there had been no regular meeting during the war period, it was felt that a regular four-day session would be desirable; and that the meeting should begin on Tuesday, May 7, 1946, and be carried on through Friday noon, May 10, 1946. It was so voted.

13. **"California and Western Medicine":**

(a) Attention was called to trade printing conditions which have much to do with the somewhat delayed and irregular appearance of CALIFORNIA AND WESTERN MEDICINE. The printers are making efforts to overcome their manpower difficulties as rapidly as possible.

(b) Attention was also called to a letter received from the Trustees of the American Medical Association, dated October 3, 1945, in which the A.M.A. Trustees served notice that the A.M.A. Coöperative Medical Advertising Bureau might be discontinued at the end of the current year. It was stated that this subject had been given over to the Executive Secretary for further consideration.

14. **Association of California Hospitals:**

Doctors Gilman and Cline made comment concerning the plan submitted to the Executive Committee of the C.M.A., by George U. Wood, Chairman of the Blue Cross Committee of the Association of California Hospitals.

Executive Committee Chairman Cline outlined to the Council the discussions that had taken place relative to the plan submitted by Doctor Wood, having the title, "The American Plan."

Mention was made of the modifications which the C.M.A. Executive Committee felt should be made in regard thereto. Doctor Cline referred to the several committees that had been appointed by the C.M.A. Council at the instance of the Association of California Hospitals and the three Blue Cross organizations, stating that out of the discussions and presumable agreements, nothing had as yet developed, beyond the proposed action submitted by Dr. Wood.

Doctor Cline referred to a letter that had been sent by the C.M.A. Executive Committee in reply to Doctor Wood. This letter emphasized the necessity of having a uniform statewide plan in Blue Cross activities and that it was important to have direct corporate authority vested in the conference groups.

Upon motion made and seconded, it was voted that the California Medical Association appoint a conference committee consisting of five members, the committee however, to have no power for commitments. The committee consists of: Doctors Sam J. McClendon, San Diego; E. Vincent Askey, Los Angeles; Chester L. Cooley, San Francisco; John W. Cline, San Francisco; and Ernest W. Page, Berkeley.

Concerning the plan submitted by Doctor Wood, other discussion followed. Incorporated in Doctor Wood's statement were the following:

The Board of Trustees of the Association of California Hospitals approved the recommendation of the Blue Cross Committee, recommending to the California Medical Association that we pool our efforts in the development of a uniform plan for the State of California.

The plan proposes the following features:

1. It should be sponsored by the California Medical Association and the Association of California Hospitals and other allied professions.

2. It should be voluntary rather than compulsory.

3. It should assure the individual free choice of doctor, dentist and hospital with no interference with the professional relationship between physicians, dentists and patient, or between physician and hospitals.

4. It should place emphasis on community welfare and should be non-profit in operation. Surplus earnings, after safe reserves have been provided, should be used for the benefit of subscribers in the form of reduced premiums or increased benefits.

5. Benefits should be comprehensive.

6. The plan must be free of political control.

7. The setting up of an over-all governing board of control is proposed, consisting of equal representation of physicians, hospitals, industry and the public to administer a uniform plan of prepayment voluntary insurance covering medicine, surgery and hospitalization.

After further discussion, Doctor Cline reported that at the 195th meeting of the Executive Committee, held on September 26, 1945, the following modifications were suggested by the C.M.A. Executive Committee:

The mimeographed circular *"The American Plan,"* submitted by George M. Wood, Chairman of Blue Cross Committee of the Association of California Hospitals was considered paragraph by paragraph and following tentative agreements reached in regard thereto:

(a) In the diagram, words "equal," "advisory," and "public" to be deleted. Word "Labor" to be inserted as

of equal importance as "Industry." Word "Agriculture" to be substituted for word "Public."

(b) In the subparagraphs under side heading, *"The plan proposes the following features,"* notations to be made as follows:

Paragraph (1), no change.

Paragraph (2), no change.

Paragraph (3), delete word "dentist" with addition of sentence, "When, as and if Dental Care is included, then equitable representation of the Dental Profession will be made."

Paragraph (4), place period after word "welfare" in first line. Delete remainder of the paragraph.

Paragraph (5), add words, "as possible," to then read "Benefits should be as comprehensive as possible."

Paragraph (6), no change.

Paragraph (7), delete word "equal." After word "hospitals," insert word "labor." Delete word "public" and insert in lieu thereof, word "agriculture."

* * *

Tentative Agreement that it would be desirable to have a large Governing Board or Board of Directors say of 30 members composed of 6 members each, respectively representing the groups of (1) Physicians, (2) Hospitals, (3) Labor, (4) Industry, and (5) Agriculture. This body to meet several times a year.

* * *

The Governing Board to elect an Executive Committee consisting say, of three physicians and two hospital representatives. This committee to be the active administrative head of the organization.

* * *

Discussion followed on whether the three Blue Cross Plans now operating in California could amalgamate as one organization; or whether, that failing, the Association of California Hospitals would wish to bring a new statewide Blue Cross group into being (in conjunction, with or without one or more of the three existing California Blue Cross groups.)

15. Legal Department:

Legal Counsel reported the present status of the Industrial Accident Fee schedule. The Council was informed that the Industrial Accident Fee Schedule Committee had approved modifications in the fee schedule previously submitted by the Association to the Industrial Accident Commission, these modifications being: home visits, $2.50; hospital visits, $2.50; double operations, one and one-half times the fee for a like single operation.

Counsel then recommended that the new fee schedule, as modified, be forthwith submitted to the Industrial Accident Commission, with a petition urging its adoption.

Counsel pointed out that under the reorganization bill recently passed by the Legislature, there are now seven members of the Industrial Accident Commission instead of three members, as was formerly the case, and that of these seven, three of the new commissioners reside in southern California. For this reason, Counsel requested permission to associate a southern California attorney in all matters before the Industrial Accident Commission.

On motion, seconded and unanimously carried, the recommendations of the Legal Counsel were approved, and the Executive Committee was authorized to arrange with Legal Counsel for the compensation of the Southern California associate attorney.

16. Woman's Auxiliary:

Receiving comment were the following: A letter of October 15, 1945, from Mrs. Ralph Eusden, President of the Woman's Auxiliary to the California Medical Association, enclosing a letter of June 19, 1945, to Mr. Stanley Cochems, concerning *The Courier;* and a letter of September 18th, 1945, to Mrs. Eusden from Mr. Cochems, and a resolution adopted by the Directors of the Woman's Auxiliary to the C.M.A. In the new arrangement, *The Courier* of the Woman's Auxiliary would be considerably increased in size.

17. Instructions to C.M.A. Delegates to A.M.A.:

Doctor Dwight H. Murray, Chairman of the C.M.A. delegation to the A.M.A., reported that the delegates and alternates had been in session during the noon hour and had agreed upon general policies to be followed in relation to the meeting of the House of Delegates of the American Medical Association to be held in Chicago on December 3-6, 1945.

It was stated that Delegates Wilbur, McClendon, Murray, McLean, Askey, Cline, and Cass would be able to attend, and that Doctor Madsen, alternate to Delegate Goin, would also attend, thus completing the delegation of eight from the C.M.A. to the A.M.A. House of Delegates.

18. Committee on Public Policy and Legislation:

(a) Doctor Dwight H. Murray, Chairman of the C.M.A. Committee on Public Policy and Legislation, made a brief report concerning the present status of legislative matters.

(b) A letter was read from Doctor A. J. J. Rourke, concerning Senate Bill 191, through which some five million dollars would be appropriated for a nationwide survey of hospitals. The Council voted to endorse S. B. 191.

(c) Mr. Read discussed Federal and State legislation, referring to the following items: Wagner Bill; Pepper Bill for extension of E.M.I.C.; the possible addition to the United Public Health League of the States of New Mexico and Wyoming; the Washington office of the United Public Health League; tours by Assemblyman Kraft to Alameda, San Mateo, Santa Clara, and San Francisco counties; possible special session of Legislature in December or January; and, obtaining opinions of legislative candidates on the subject of compulsory health insurance.

19. Request from Physician in Del Norte County for a Component County Society Charter from the C.M.A.:

Request was received from Doctor Francis M. Stump of Del Norte County, for a county society charter for that county.

The information was given that Del Norte County had approximately 5,000 citizens, with three resident physicians. Attention was called to the by-law provision, Article V, Section 8, whereby issuance of a charter is vested in the House of Delegates, the Council having no authority.

20. C.M.A. Cancer Commission:

The C.M.A. Cancer Commission, through its Chairman, Doctor Kinney, submitted the following:

The Cancer Commission submits the following progress report:

1. The Commission has decided to revise the Cancer Commission Studies of 1934 and prepare from that a cancer manual to be distributed to the physicians in the State. The editorial committee appointed consists of Dr. Leonard G. Dobson, Chairman, Dr. Clarence J. Berne, and Dr. Otto H. Pfleuger.

2. The Commission is attempting to organize a Cancer Committee in every county medical society in California. A bulletin has been prepared for each county committee outlining the functions of such a committee as visualized by the Commission.

3. The Commission is starting a preliminary survey of the cancer facilities in the State. A questionnaire has been

sent to each of the approved cancer clinics. A second questionnaire has been prepared to be sent to the Cancer Committee of each county medical society regarding the available facilities and needs in their county.

4. The Commission has appointed a committee consisting of Drs. Rinehart and Wood to contact the California Department of Public Health to discover the possible methods of coöperation between the California Medical Association and the Health Department in cancer control programs.

Dr. Wilton L. Halverson, Director of Public Health, has submitted a request to the United States Public Health Service to assign a medical officer to survey the cancer situation in California and advise him as to procedures. The Cancer Commission believes that the California Medical Association should join the Director of Public Health in this invitation to the United States Public Health Service to make a survey of the cancer situation in California. The Commission, therefore, respectfully suggests to the Council that they issue a request through channels to the United States Public Health Service paralleling the request of Dr. Halverson or that they direct the Commission to issue such a request in the name of the California Medical Association.

On motion duly made and seconded, it was voted that the recommendations submitted be approved and that the Cancer Commission be authorized to so inform the interested parties concerning a survey of cancer facilities in California.

21. **Committee on Rural Medical Service:**

It was agreed that the Chairman of the Council should appoint a sub-committee on Rural Medical Service, in response to a request from the A.M.A. Special Committee on Rural Medical Service. (Chairman Gilman appointed the C.M.A. Committee on Health and Public Instruction for this service: Drs. J. C. Geiger, E. Earl Moody and C. M. Burchfiel.)

22. **Los Angeles County Medical Association Invites C.M.A. Council to attend its 75th Anniversary:**

Secretary E. T. Remmen of the Los Angeles County Medical Association, and Speaker E. Vincent Askey, extended an invitation to the members of the Council and their ladies, to be the guests of the Los Angeles County Medical Association on the occasion of the 75th Anniversary of that county unit. The celebration will take place on Thursday, January 31, 1946.

On motion made and seconded, it was voted to accept with thanks the gracious invitation.

23. **Time and Place of Next Meeting:**

On motion, it was voted that the next meeting of the Council should be held in Los Angeles on Friday, February 1, 1946.

24. **Executive Session:**

The Council went into Executive session. It was agreed that action on the matters considered be deferred until the next meeting of the Council.

25. **Adjournment:**

There being no further business, the meeting was adjourned.

PHILIP G. GILMAN, *Chairman,*
GEORGE H. KRESS, *Secretary.*

Our country [America] has liberty without license and authority without despotism.

—James, Cardinal Gibbons, *Address,* at Rome, 25 March, 1887.

Intellectually I know that America is no better than any other country; emotionally I know she is better than every other country.

—Sinclair Lewis, *Interview in Berlin,* 29 Dec., 1930.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (25)

Alameda County (3)

Cholfin, Mollis, *Oakland*
Footer, Wilson, *Oakland*
Henley, R. Bruce, *Berkeley*

Merced County (1)

Buckley, John P., *Merced*

Orange County (2)

Thysell, Nels John, *Orange*
Wickett, William H., Jr., *Fullerton*

Sacramento County (2)

Fanucchi, Dino W., *Sacramento*
Iki, George S., *Los Angeles*

San Francisco County (14)

de Silva, Paul L., *San Francisco*
Escher, Earl W., *San Francisco*
Fenlon, Roberta F., *San Francisco*
Garthwaite, Mary E., *San Francisco*
Hillstrom, Earl M., *San Francisco*
Howard, Frederick S., *San Francisco*
Low-Beer, Bertram V. A., *San Francisco*
Mendel, Robert A., *San Francisco*
Musser, Don Carlos, *San Francisco*
O'Gara, Louis A., *San Francisco*
Salisbury, Peter F., *Berkeley*
Schindler, Meyer, *San Francisco*
Schmitz, William G., *San Francisco*
Torkelson, Harold P., *San Francisco*

San Joaquin County (1)

Chope, H. D., *Stockton*

Yuba-Sutter-Colusa County (2)

Culiver, Norman, *Marysville*
Edwards, D. Ermorine, *Marysville*

Retired Members (3)

Nuttall, John P., *Los Angeles County*
Slemons, J. Morris, *Los Angeles County*
Visscher, George, *Los Angeles County*

---

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Boyer, Horace Russell. Died at Glendale, November 10, 1945, age 68. Graduate of Unversity of Maryland School of Medicine, Baltimore, 1903. Licensed in California in 1909. Doctor Boyer was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Breuer, Miles John. Died at Los Angeles, October 14, 1945, age 56. Graduate of Rush Medical College, Chicago, 1915. Licensed in California in 1943. Doctor Breuer was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Cooper, Harold John. Died at Fresno, November 5, 1945, age 51. Graduate of Stanford University School of

Medicine, Stanford University-San Francisco, 1921. Licensed in California in 1921. Doctor Cooper was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Desrosier, George Washington. Died at Colusa, October 25, 1945, age 66. Graduate of Cooper Medical College, San Francisco, 1894. Licensed in California in 1895. Doctor Desrosier was a member of the Yuba-Sutter-Colusa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Driver, Camilles Ogden. Died at Los Angeles, August 2, 1945, age 48. Graduate of Rush Medical College, Chicago, 1922. Licensed in California in 1922. Doctor Driver was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Khuri, Kalim Basil. Died at Hollywood, November 4, 1945, age 58. Graduate of Columbia University College of Physicians and Surgeons, New York, 1915. Licensed in California in 1939. Doctor Khuri was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

MacMillan, John Kerr. (Captain, Army of the United States.) Killed in Action, October 5, 1945, in Iran, age 37. Graduate of College of Medical Evangelists, Loma Linda, 1938. Licensed in California in 1938. Doctor MacMillan was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Parkinson, Sidney Nuttall. Died at Piedmont, October 31, 1945, age 46. Graduate of University of Pennsylvania School of Medicine, 1926. Licensed in California in 1930. Doctor Parkinson was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Sagnella, Lawrence Alexis. Died at West Los Angeles, October 29, 1945, age 45. Graduate of Tufts College Medical School, Boston, 1925. Licensed in California in 1935. Doctor Sagnella was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Waterman, Helen Jane. Died at Berkeley, October 14, 1945, age 88. Graduate of Women's Medical College of Pennsylvania, 1897. Licensed in California in 1897. Doctor Waterman was a Retired Member of the San Francisco County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

George Eliot (1819-1880).—From the Journal and letters of George Eliot, born Mary Ann Evans, it is evident that she was never in robust health, a factor that often affected her writings. All the more credit to her that she contributed such outstanding novels to English literature as "Adam Bede" and "Silas Marner." Her death occurred after a brief illness, brought on by a cold and throat ailment, that she developed after sitting in a draft in an over-heated concert hall.—Warner's *Calendar of Medical History.*

OBITUARIES

Henry Stanley Rogers
1884—1945

The difficulty of putting thoughts into words and onto paper is never more present than in writing about a friend all those things which were deserved but probably unmentioned during his lifetime. At such times our own shortcomings arise to confront us. Our only defense can be that we have tried in our friendship to express those sentiments which we have not put into words; those things which we felt but did not talk about.

The death of Henry Stanley Rogers came as a shock to many, an anticipated event to others and a release to Henry. In ill health for more than a year, he went to his reward while instructing his attending physician in the intricacies and technique of handling his own case. Never could he have better demonstrated the courage which constituted a large element of his character.

Henry Rogers, or Stanley as his family and some intimates called him, will never be rated as one of the great men of our time. His career did not lend itself to consideration of greatness but his steadfast character, his understanding heart and his normal courage were all elements which we seek in great men. To that extent, at least, we can call him great in his own small way. Born on a farm, educated in the manner of all other physicians of his time, he came out of medical school just in time to enter the Army Medical Corps in the first World War. Serving with distinction, not seeking or receiving much recognition in the way of military rank, he carried on his duties even in the face of a gas attack from which he saved his patients but could not himself escape. The results of that attack were to remain with him throughout his life and undoubtedly to contribute to his final illness.

At the war's end Henry and his wife, the former Jean DeHart, came to Petaluma, outlanders with a love of the soil and an ambition to do their best in the com-

munity of their choosing. Proof of their outstanding success in this endeavor came at Henry's funeral, where not one but many friends made the same comment, to the effect that there was not a better loved man in the community.

Zeal, where we find it, often expresses itself in various directions, and in Henry Rogers this was the case. His interests encompassed more than his own practice, his family, his home, his community. He early took an active interest in the professional, social and economic aspects of the practice of medicine. He brought into organized medicine the point of view of the rural man, the citizen of California who may be forgotten in a state which is preponderantly rural but dominated by large metropolitan areas. On the Council of the California Medical Association, Henry Rogers represented the sound judgment of the truly mature man, at the same time representing to a majority of metropolites the cause of our many rural residents. His counsel was ever sound, honest and contributory to the common good. As President of the California Medical Association, 1941-1942, he displayed all the characteristics of leadership which his colleagues recognized in electing him to that post.

Henry will be missed throughout California. He will also be missed at Diamond Lake, Oregon, where his summer cabin and his bright red fishing canoe were known to all. In his fishing he exhibited the same skill, patience and canny understanding that he brought to his whole professional and personal life. His intimates will always treasure his friendship and remember him, his friends will miss him. We have all suffered a loss in his death.

John Dysart Dameron
1869—1945

On Tuesday, September 25th, the senior member of the San Joaquin County Medical Society, Doctor John Dysart Dameron passed away, after a lingering illness of several years' duration. Doctor Dameron was in his 79th year and had been practicing medicine in San Joaquin County since 1895, until his retirement several years ago. The Doctor was born in Prairie Hills, Missouri, June 11, 1867. He was graduated from the Missouri Medical College of St. Louis, Miss., now the Medical department of Washington University, on the 24th of March, 1894, and was licensed to practice in California in 1895.

In his earlier years in practice, Dr. Dameron was in charge of the San Joaquin General Hospital from the late nineties to 1912, at which time he built a private hospital in Stockton, which still bears his name, Dameron Hospital. During his long career he was primarily interested in surgery and earned a deserved and enviable reputation as a successful and bold surgeon. While at the San Joaquin General Hospital he began to close infected abdomens without drainage.

For many years he made regular trips to the Mayo Clinic and was a life long member of the Surgeons Club of Rochester, Minnesota.

In 1940 the San Joaquin County Medical Society met in a special dinner meeting held at the Hotel Wolf at which time Doctor Dameron was honored as the dean of the medical group of the San Joaquin County Medical Society. Seventy-two fellow practitioners, the largest gathering of medical men ever held in this county, paid him this tribute. His place will be hard to refill.

James T. M. Allan
1870—1945

On August 25th the medical staff of the California Hospital, in Los Angeles, lost one of its most loved members, Dr. James T. M. Allan. The death of this kind doctor ended a service to the hospital almost as long as the history of the institution, itself.

In 1903 Dr. Allan was the sixth youngest doctor to serve an internship at the California Hospital and, upon the completion of that service, he immediately began the private practice in Los Angeles that was to continue until his death.

Mr. R. Ernest Lamb, who conducted the memorial service for Dr. Allan, described him as St. Paul described the Apostle Luke, by calling him the "Beloved Physician."

"Many are the number who knew him as a fellow physician, one whose counsel was sought and valued, one who always was true to his solemn responsibility as a follower of the medical profession. His desire to heal, and save lives, and to minister to the needs of those who suffered came from his heart. As a comrade in service, he will be remembered as the beloved physician.

"Many others sought him as a doctor and discovered that they found not only a skilled physician but a warm and faithful friend. He was a man of rich and abiding friendships. To those he will be remembered as the beloved physician."

In the hearts of many, the name of Dr. Allan means love and service for others. There is no one who can take his place. He was a beloved physician.

Edward S. Babcock
1898—1945

Edward Saunders Babcock died in Sacramento, on September 3, 1945, at the untimely age of 47, of complications incident to an essential hypertension. He practiced pediatrics in Sacramento for 20 years. Though born in Porterville, N. Y., he lived his early years in Riverside, California. Graduating from the University of California Medical School, San Francisco, in 1923, he served one year as intern at the University of California Hospital and one year as Resident Physician in the Children's Hospital of Oakland before commencing practice in Sacramento.

Doctor Babcock was a veteran of World War I. For 16 years he was consulting physician of the Sacramento Children's Home and he was a past president of the Sacramento Society for Medical Improvement. He was also a past president of the Northern District Medical Society. He was a member of the California Acamedy of Medi-

cine, the American Pediatric Society, Washington Lodge No. 4 F. and A. M., the Scottish Rite, the Ben Ali Temple of the Mystic Shrine and Royal Order of Jesters.

To those who knew "Eddie Babcock," his passing is more than a momentary shock. The children who were his patients, their parents, and his medical associates whose privilege it was to work with him will long remember his sterling character and unforgettable personality.

Certain indelible impressions come to mind as one recalls pleasant associations with this colleague. They emphasize his outstanding characteristics, as kindness and tolerance of others' opinions, and painstaking scientific thoroughness and truthfulness in the finest medical tradition.

In his professional relationships Doctor Babcock was particularly outstanding. He was a strong organization man and gave generously of his time to medical affairs, was a faithful attendant at all medical meetings and a valiant partisan in all things pertaining to the welfare of the medical profession and the ethical practice of medicine. He was especially considerate of younger men entering practice and was more than generous in guiding and advising them.

Doctor Babcock's family life was another fine and happy chapter and his home ever a haven of friendship, hospitality and good cheer. He is survived by his wife and three daughters.

No words can adequately describe the high fidelity and courage displayed by Doctor Babcock during the final months of his illness. In those last days he was ever calm and unshaken. At all times he was his usual friendly, kindly self, interested in others, in events of the day and never by word or gesture intruding upon others his own tragedy inevitably approaching.

To sum up our colleague whose passing was so untimely—he represented all that was fine and good as a doctor, a husband and father, as a citizen and as a man.

D. SCHUYLER PULFORD.

MEDICAL EPONYM

Wilson's Disease

The essay "Progressive Lenticular Degeneration: A familial nervous disease associated with cirrhosis of the liver" formed part of a thesis by S. A. K. Wilson (1878-1936). The monograph appeared in *Brain* (34:295-509, 1912), and the following is a quotation from pages 486 and 487:

"Progressive lenticular degeneration is a disease of the motor nervous system, occurring in young people and very often familial. It is not congenital or hereditary.

"It is progressive and fatal within a varying period; acute cases may last only a few months . . . the average duration of chronic cases in four years.

"It is characterized by a definite symptom-complex, whose chief features are: generalized tremor, dysarthria and dysphagia, muscular rigidity and hypertonicity, emaciation, spasmodic contractions, contractures, emotionalism. . . .

"Although cirrhosis of the liver is constantly found . . . there are no signs of liver disease during life. . . .

"The chief pathological feature of the disease is bilateral symmetrical degeneration of the putamen and globus pallidus, in particular the former. . . .

"A constant, essential and, in all probability, primary feature of the pathology of the disease is cirrhosis of the liver, not syphilitic or alcoholic."—R. W. B., in *New England Journal of Medicine.*

Life is not measured by the time we live.
—George Crabbe, *The Village*, Bk. II.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

	October, 1944	*October, 1945*
Commercial Program.....	93,000	151,233
Rural Health Program	2,011	2,178
Housing Program	15,200	7,098
Total Membership	110,211	169,509

The Board of Trustees of California Physicians' Service held a regular meeting on October 20th, at the Town House, Los Angeles.

It was reported that the membership as of this date was approximately 170,000. Acquisition activities during the month of September showed an enrollment of 10,940 new members. This was offset by a loss of 4,731. This loss is heavier than has been reported in previous months, and represents the effects of reconversion and shifting labor conditions on the plan.

Under professional membership, there is still a steady increase in the number of physicians who are allying themselves with the organization, and as of the end of September, total professional membership reached 5,625. There is noticeable activity on the part of physicians returning from service. Individual calls are being made to these men, the history of C.P.S. during the time they were in service is being reported to them, and they are being brought up to date on its present status and current procedures. Many of these physicians have expressed a great deal of satisfaction with present conditions, and also with the improvement in the method of handling patients which has taken place since they last rendered service.

It was reported to the board that the professional membership generally has graciously understood the necessity for the $2.00 unit value during the reconversion period. This is a factual demonstration of the support given by professional members of C.P.S.

Various phases of the actuarial status of C.P.S. were thoroughly discussed by the board, to see where other economies might be made. However, it was the consensus that at least six months or more experience under the new rates should be analyzed before any changes of this nature are made. It was also the consensus that the product which is now being offered to the public is excellently adjusted to the practice of medicine, and also provides a maximum of benefits to the beneficiary. These two principles, being the main objective of prepaid medical care plans, should be preserved.

---

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.
Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization through W. M. Bowman, Executive Director.

Of interest to the individual physician was a report of income under private practice, in a consecutive series of 100 cases, against income under C.P.S. for a series of 100 consecutive cases of a similar nature. The results showed a very satisfactory comparison, and on the basis of this report, it was suggested that the Council of the California Medical Association make an independent inquiry of a similar nature from physicians in the various specialties, in different areas of the state. The results of this should be of considerable interest.

The Public Relations Program is being geared more and more to the coming Public Relations Program of the California Medical Association. Several communities in the state have requested so-called "community programs," in which the physicians and local business have indicated their desire to join together and promote prepaid medicine in their communities.

The board was advised that notice had been given to the Marin Housing Authority to close Marin City as of November 30th. This has now been accomplished. In the interim, due to a sudden drop-off of membership in the Vallejo area, because of economic conditions relative to wages and the intensification of turnover in labor, notice has been given to the Vallejo Housing Authority that C.P.S. would discontinue in that area by the first of the year. This will constitute complete disappearance of this special program which was in effect during the war time period.

Negotiations are still under way, and progressing, to develop a new Rural Health Program which can more adequately reach increasing numbers of the farm population of this State.

The board was given current reports on the activities of the C.M.A. Study Committee, as well as the C.M.A. Advisory Planning Committee and the Hospital Association Committee.

The board authorized bonuses to employees at Christmas, in the interest of strengthening personnel relationships and rewarding loyal employees for their services to C.P.S. This applies to the general administrative staff, but excludes the executives.

Guests at the meeting were Mr. Mortenson, Secretary of the Retail Druggists' Association of Southern California, and Mr. Warnack, Vice-President of the California State Pharmaceutical Association. They indicated a desire to find a common ground upon which the pharmacists and physicians of this State could present a solid political front in mutual coöperation.

In the interim since the board meeting, the representative of the National Physicians' Committee, which is making a study of medical service plans throughout the country, spent several days at the C.P.S. offices in San Francisco. C.P.S. has also been visited by an actuary employed by the Assembly Interim Committee of the State Legislature. Both were given free access to information, and special information is being prepared, at their request.

CHESTER L. COOLEY, M.D., *Secretary.*

The less America looks abroad, the grander its promise.
—Emerson, ***Uncollected Lectures: Character.***

E Pluribus Unum. (One from many.)

—*Motto*, used on the title page of the *Gentleman's Journal*, January, 1692. Motto for seal of the United States proposed originally on 10 August, 1776, by a committee composed of Benjamin Franklin, John Adams and Thomas Jefferson. Adopted 20 June, 1782. The motto was added to certain coins in 1796. The actual selection of the motto has been claimed for Pierre Eugène du Simitière, a Swiss artist, who was employed by the committee, shortly after the Declaration of Independence, to submit a design for the seal—a design which was not accepted.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

On Coöperation Between California State Office of Selective Service System and California P. and A. Service for Physicians

(COPY)

FEDERAL SECURITY AGENCY
PROCUREMENT AND ASSIGNMENT SERVICE
FOR PHYSICIANS—CALIFORNIA
Field Office: Room 1331, 450 Sutter Street
San Francisco 8, California

November 8, 1945.

George H. Kress, M.D., Secretary-Editor, *Addressed.*

I am enclosing a copy of a letter which might be published in the Journal of the CALIFORNIA AND WESTERN MEDICINE if you feel it advisable. It is of interest because it shows the fine coöperation the Procurement and Assignment Service as well as the Postwar Planning Committee of the California Medical Association is receiving from the various agencies involved in the relocation of veterans. The Procurement and Assignment Service and the medical profession has had the greatest help and coöperation from the State Office of the Selective Service System.

With my kindest regards, I remain,

Sincerely yours,

HAROLD A. FLETCHER, M.D.,
California State Chairman for Physicians, Procurement and Assignment Service.

* * *

(COPY)

STATE OF CALIFORNIA
DIRECTOR OF SELECTIVE SERVICE
Plaza Building, Sacramento 14

October 16, 1945

Subject: Your Lettet re: ————

Dear ————:

The problem which you present concerning Dr. ——— has interested me considerably, insomuch as it resulted in my learning of a number of activities engaged in by Procurement and Assignment, which activities I was not acquainted with until I made inquiry as a result of your letter.

My first impression was that a doctor such as Dr. ———, certainly has the right to settle in whatsoever spot he so desires to settle as long as it is in the jurisdiction of his licensesure. I was certain that Procurement and Assignment could not "dictate the location of such a native son and veteran." Such is the fact. Procurement and Assignment cannot dictate the location of a doctor, but the Procurement and Assignment Service is still being asked by the California Medical Association as to the need of a doctor in specific spots and it is being asked for opinion as to whether it deems it fair and right that a particular doctor should switch his activities from a town where he once practiced to another town of his desire.

The reasons for approaching Procurement and Assignment for a recommendation with respect to a doctor's location are many. Apparently, first and foremost in the minds of those requesting such recommendation, is that of protecting the veteran physician who is still in the Army, and who, reasonably, should be assured that he may return to his old practice without having others

come in and take away his practice while he is helpless to protect it. Suppose we utilize the situation surrounding Dr. ——— as an example: Let us say that Dr. X, a surgeon who had builded a sizeable practice in —— ——, still remains in the service, and must so remain in the service for some six or more months. The question arises as to whether it is cricket for Dr. ——— to now move to —— ——— and establish a surgical practice which might prove to be detrimental to Dr. X's interests even after he returns. In other words, while Dr. X is helpless to return to —— ———, Dr. ——— enters —— ———, even though Procurement and Assignment feels that —— ——— is presently not in urgent need of another surgeon, and, likely, could not provide enough surgical practice for both Dr. ——— and the returning veteran after the veteran returned. Remember that the Procurement and Assignment recommendation to ——— ——— Medical Society does not preclude the possibility of Dr. ——— going into —— ——— and establishing a practice even though such recommendation might make the ——— ——— doctors unhappy if Dr. ——— did go to —— ——— despite Procurement and Assignment's recommendation that his entry there might upset the normal balance of medical needs.

By having made a 5-year study of the overall distribution of available medical care in California, Procurement and Assignment is recognized as being in an excellent position to advise where new doctors should locate as well as to advise concerning the justification (or lack of it) in the case of a doctor who wishes to dislocate from one area to locate in another. Since the California Medical Association recognized that the Procurement and Assignment Service had collected such extensive and important and guiding data concerning the medical needs of California, they approach Procurement and Assignment and ask them to act in an advisory capacity, and, it should be stressed that their recommendations are advisory only. This answers your question as to the legality of any policy dictated by Procurement and Assignment. With respect to dictating location, there is no legal basis.

There is probably a good reason why Dr. ——— has not yet heard from Dr. ———. Dr. ——— is involved only with the loca set-up. When Dr. ——— receives a letter asking whether it is proper and right and in accord with needed medical distribution for one to settle in —— ———, Dr. ———, who is acquainted with the local survey, writes to the Chairman of Procurement and Assignment in California, gives said Chairman his best advice as to the need of the specific doctor desiring entrance into the community, and further advises the State Chairman concerning the time expectancy when doctors who have been established in —— ——— prior to entrance into the services will return. The State Chairman coördinates his local opinion with the picture as seen from the State level. Then, in turn, the State Chairman makes direct recommendation to the County Society concerning the need for the doctor, and discusses the right or wrong of the question as to his coming in prior to the return of those who expect to return shortly. Unquestionably, you recognize that such processing, followed by the Procurement and Assignment's report, would influence a local Medical Society as to the acceptance or non-acceptance of a member into its fold. To the extent of bothering by repetition, stress should again be put upon the point that whatever the decision the County Society makes would not bar the doctor from coming into the new location other than the bar which has been placed there by a lack of good will.

The reason why Dr. ——— has not had direct response from Dr. ——— likely may be laid to the delay caused by the processing from his office to the State Chairman and, then, back to the County Society.

If anyone should object to this method of attempting to properly distribute medical care to the population of the State, there is one great and saving point to such objection. It is as follows: The Procurement and Assignment Service has accomplished a magnificent job up to this time and, therefore, it is likely to continue to serve both the public and the profession well. From one who has had the opportunity to be closely acquainted with the work of Procurement and Assignment during the last five years, I can truthfully say that their task has been a difficult one, their work has been sincere and honest, they have made decisions without prejudice and those who abide by their decisions will not be led astray.

BERT S. THOMAS,
Colonel, MC,
State Medical Officer.

cc: Dr. H. A. Fletcher, Chm.,
P. & A. Service for Physicians

New Discharge Setup

The soldier with a big family will be eligible to get out of the Army after December 1, regardless of his point score.

The War Department announced on November 16 a series of modifications to the present discharge system, including a reduction of point scores, which it said would add 783,000 men and women to the number eligible for release.

Later, the Navy announced point revisions for officers and enlisted men in previously "frozen" classifications which it said would qualify nearly 10,000 for release by January 1.

By December 1, the Army estimates it will have either discharged or have eligible for release, approximately 5,000,000 men. This figure will include more than 3,500,000 actually discharged and 1,483,000 eligible for discharge.

This will mean that of the 8,300,000 men in the Army on V-E day, 3,300,000 will be in service. The Army, however, is larger than that because of inductions and enlistments.

Men with three or more dependent children under 18 years of age will be eligible for release. Length of service doesn't matter. Previously 12 points were allowed for each such child up to a maximum of three.

The new point score for enlisted men will be 55, instead of the present 60. . . .

Male officers, except those in the medical department, will be able to ask for release if they have four years and three months' service. Their point score will be cut from 75 to 73. The Army said it would have an announcement before the middle of next month regarding discharge requirements for both men and women medical officers.

Hoff General Hospital to be Closed

The Army's Hoff General Hospital, a city within itself, occupying 102 buildings and 56 acres, will close November 30, it was announced in Santa Barbara on November 1.

The first group of 350 civilian employees received civil service notice of termination of duties effective November 16. Officers explained patients will be transferred to other hospitals in the West between now and that date.

During the latter part of the month only a few officers and men were on duty to close the institution. In addition to the property inside the city the hospital operated a 15-acre farm and until recently used one of the largest elementary school buildings for special rehabilitation work.

Navy Approves Monterey for Fleet School

A plan to educate thousands of officers for a powerful postwar Navy has been approved by Secretary Forrestal, and a board has recommended that the school be located at Monterey, California.

The Navy announced the plan on November 5, and officials said it would assure equality of opportunity to officers who have not graduated from the naval academy at Annapolis.

A board headed by Capt. H. A. Spanagel has recommended that the permanent school be located at Monterey, and that a temporary school be established at Quonset, R. I.

The general line school would consist of a one-year course. Naval officers emphasized that the school could not be considered a West coast equivalent of Annapolis...

Speculation as to where the Navy would establish the institution in the Monterey area centered around the Del Monte Hotel.

However, S. F. B. Morse, head of the Del Monte Properties Company, which operates the hotel, said the Navy had not committed itself to him.

The hotel and its extensive grounds have been used by the Navy since the very beginning of the war. It now houses a Navy radio school.

(Note. Hotel Del Monte in recent years, has been the place of choice for annual sessions of the California Medical Association. It had been hoped that the Navy would soon release the property to the Hotel Management.)

Internal Medicine Conference at Letterman General Hospital

A conference on internal medicine was held at Letterman General Hospital in San Francisco, California, November 7 and 8, under the direction of Brigadier General Charles C. Hillman, Commanding General of the hospital, and was attended by medical chiefs, consultants, and surgeons of various hospitals and service commands.

Representing the Office of the Surgeon General, Brigadier General Hugh J. Morgan, Chief Consultant in Medicine, spoke on the rôle of medicine in the Pacific war and Major Clarence Livingood, Consultant in Dermatology, took part in a panel discussion of diphtheria and lichenoid and allied skin diseases.

Other subjects under discussion were rheumatic fever, coccidioidomycosis, and hepatitis. A program of dedication was planned for the new swimming pool at Letterman, and members of the conference were conducted on a tour of the hospital.

World War II Casualties

Sixty-three per cent of the wounds received in World War II were those of the upper and lower extremities, with the lower extremities the heaviest proportion, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently before the Milwaukee Association of Commerce.

"There were 207,754 men of the United States Army killed in action and 571,490 wounded," General Kirk stated. "Of those wounded, 363,322 returned to duty after hospitalization and 25,145 died. These figures indicate that the rate of those wounded who died was nearly twice as great in World War I."

Of the 15,000 amputees of World War II, 14,000 needed artificial limbs, 7,000 of whom still remain in general hospitals. The balance either returned to civilian life or remained on duty as instructors for other amputees, the General continued. There have been two quadruple amputations and nine triple amputations recorded in World War II. Of the 14,000 needing prostheses, 95 per cent have lost one arm or leg, and five per cent have suffered two major amputations.

Outlining the Army's job in medical care and rehabilitation of the wounded, General Kirk also stressed the part of the American public in helping the returned veteran, and concluded, "Too many men in the last war became social derelicts because too little responsibility was assumed by business and industry in placement of the individual in a job commensurate with disabilities. Those men have won the war, now let us help them win the peace."

General Somervell Reports on Army Medical Department

In his annual report to the Under Secretary of War and the Chief of Staff, General Brehon Somervell, Commanding General, Army Service Forces, made the following remarks concerning the Army Medical Department:

"The American Army is the healthiest army in history.

"Unbelievable strides have been made by Army doctors even as the war progressed, not only in surgery and care of the sick but in preventive medicine.

"Bold and successful use of sulfanamides and penicillin reduced the fatality rate of meningitis from 38 per cent in the first World War to three per cent in 1944, pneumonia from 24 per cent to 0.7 per cent, dysentery from 1.5 to only one recorded death. Deaths from malaria have dropped to an astounding low. In 1917-1919 there were 0.2 deaths per hundred cases . . . today the number is 0.06 per hundred.

"Great advances were made in the fiscal year in the uses of whole blood and penicillin. In North Africa the Army doctors discovered that blood plasma, although it did have a remarkably beneficial effect, could not substitute for whole blood in cases of the most severe shock. Blood banks set up in the United States sent 206,000 pints of whole blood to overseas theaters in nine months.

"Penicillin, for all its value, originally had shown a tendency to disappear from the blood stream after a few hours. In order to retain its effect, Army doctors worked out a method of suspending it in beeswax and peanut oil. Given hypodermically in this combination, penicillin remained in the blood for as long as twenty hours and destroyed disease germs.

"New methods of surgical care were perfected in the fiscal year. 'Phasing' of treatment was introduced. Care of the wounded was divided into three distinct phases. The first phase took place on the battle front, where surgeons and first aid crews gave emergency treatment. Patients then were evacuated, more swiftly than ever before, to hospitals in the Communications Zone. Much of this evacuation was done by air. It was not unusual for men who could be moved to undergo their emergency treatment within the sound of guns and eight or few hours later be in bed in hospitals five hundred miles behind the lines. There the second phase . . . 'reparative surgery' was undertaken. Again men were evacuated swiftly as soon as they were able to be moved safely to hospitals in the United States. Here the final phase of surgical reconstruction and rehabilitation was undertaken.

"The results are apparent in the lowest mortality rate in the history of any army in the world . . . 4.3 per cent of the wounded.

"DDT, the magic chemical produced in vast quantities for the Army, halted many plagues among civilian populations and prevented plagues in the Army by destroying insects and vermin. The entire population of Naples underwent DDT treatment, their clothing and bedding being sprayed, and dangerous epidemics were halted before they had a chance to spread.

"Inspection of foodstuffs is another duty of the Medical Department. Thirty-three million pounds of food were inspected daily at home and overseas.

"Forward steps in the neuropsychiatry treatments resulted in the return to duty in the theatre of operations of 90 per cent of the cases of battle fatigue. Forty to sixty per cent were able to return to combat units. Before the introduction of the new treatment, which occurs immediately behind the front, only ten per cent returned."

Army Personnel Receive Influenza Inoculations

All Army personnel have been ordered inoculated during the months of October and November with a new influenza vaccine as a preventive measure against influenza epidemics, the Office of the Surgeon General has announced.

The vaccine, made by injecting influenza virus into chick embryo, is to be administered in a single injection. Experimentation with the new vaccine was started early in 1943, but sufficient quantities for mass inoculation were not made available until the present year.

Army Medical Library Honorary Consultants Meet

The second annual meeting of Honorary Consultants to the Army Medical Library was held recently in Cleveland, Ohio, for the purpose of electing officers to the association. Among those attending were: Major General George F. Lull, Deputy Surgeon General; Colonel Harold W. Jones, former director of the Army Medical Library, retired; and Colonel Leon L. Gardner, present director of the Army Medical Library.

The following officers were elected: President, Dr. John F. Fulton; Vice-President, Dr. Chauncey D. Leake; Secretary-Treasurer, Colonel Harold W. Jones. Major General Lull was elected on the Executive Committee. The action taken by Congress toward erecting a new building for the Library was one of the main topics of discussion.

Art and Medicine

Realizing the contribution which the graphic arts have made to the historical and clinical study of medicine, the Army Medical Library is endeavoring to develop the picture collection which was begun many years ago. Largely through gifts, but partially through purchase, an accumulation has been made of anatomical drawings, pictures of medical institutions, instruments, and apparatus, posters publicizing public health drives, and maps for the use of sanitary engineers.

Society's attitude toward the practitioner is reflected in the etchings, engravings, and lithographs by some of the world's most famous caricaturists. The Army Medical Library owns original examples of the work of Rowlandson, Cruikshank, Hogarth, and Daumier.

When all the pictorial material of our most recent war has been gathered, it will serve as a valuable record of the problems which confronted contemporary surgeons and physicians.

The Army Medical Library's portrait collection includes some 10,000 photographs and prints. In it are represented the most famous medical men of all ages and all countries. Æsculapius appears, as well as Osler. The Library is anxious to continue to build its collection of portraits of persons prominent in the field of medicine and surgery. Individuals are being requested to send photographs to the Library. The collection of photographs of the Library's Honorary Consultants is not complete. If you are a member and have not already provided a photograph we will appreciate receiving one. It should be 8 x 10 inches in size, autographed, marked on the back with your name, address, and the approximate date on which it was taken, and sent to: The Director, Army Medical Library, 7th Street and Independence Avenue, S. W., Washington 25, D. C.

Any other medical material you may wish to contribute to our picture, map or poster files will be gratefully received.

Veterans' Administration Medical Corps for Veterans

General Omar N. Bradley, administrator of veterans affairs, on October 20, pledged the creation of a separate medical corps for veterans and expansion of present veterans' hospital facilities.

General Bradley told the convention of Disabled American Veterans a construction program of hospitals and medical centers for veterans requiring continued medical care is in prospect.

He said the veterans administration now needs 1,300 more doctors and more than 500 specialists.

Will Offer Inducements

"Some doctors have told us they will come with us if we can offer them more attractive salaries, chances for professional advancement and the opportunity to practice modern medicine," he said.

"We mean to provide all three."

General Bradley said these inducements had been incorporated into recommended legislation which would create a medical corps in the tradition of the army, navy or the public health service.

"Emergency expansion of existing hospitals is inadequate," he said. "We now have 83,000 beds—including 11,000 emergency ones set up in present facilities—but we need 105,000 permanent beds with adequate personnel to man them."

"Reforms" in Veteran Medical Setup

As a result of an experiment successfully operated in Monmouth County, New Jersey, the Veterans' Administration hopes soon to authorize veterans suffering from service-connected disabilities to receive treatment from qualified doctors of their own choice within their own communities, instead of at Government clinics exclusively.

This program, marking one of several radical changes in medical practice within the Veterans' Administration, was outlined on November 10 by Major General Paul R. Hawley, Surgeon General of the Veterans' Administration, to the medical board of advisors of the American Legion.

General Hawley listed other "reforms" including payment of fees to specialists who will act as consultants at veterans' hospitals, development of specialized teaching at two and later three general hospitals for veterans, and institution of a rotation system for men who attended these courses of specialized instruction.

He also said plans are being made to set up an airplane ambulance service, such as was used by the Army abroad, to take emergency cases needing specialized care from remote hospitals to those equipped to give the needed service.

Near Crisis in Veterans' Hospital Program

General Omar N. Bradley, veterans' administrator, believes a record total of 81,000 veterans in hospitals have caused a near-crisis in the government's hospitalization program which can be solved in the immediate future only by overcrowding beds.

On a one-day visit to San Francisco, on October 18, the former commander of the 12th Army Corps in the European theater told a press conference that a gradually in-

creasing building program was under way. The government plans to be taking care of from 200,000 to 250,000 veterans in 20 years, he said.

The main concern of veterans' hospitals now, Bradley said, could be summed up as "shortages."

"There is a shortage of space, beds and personnel," he said, "and there are more veterans waiting than come in." It is a question of overcrowding or not having beds at all."

He said hospital records since the end of the First World War showed a peak number of patients is reached 20 years after hostilities cease. He pointed out, however, that gas attacks of World War I were responsible for most hospital cases following that war. Absence of poison gas warfare and improved medical treatment in this war have resulted in "a larger number saved," he said. . . .

He said the administration hoped to relieve the shortage of doctors through a Senate approved bill now before the House which would increase the number of physicians under civil service and provide part-time doctors by connecting the veterans hospitals with medical centers.

All But 11,000 Army Doctors to be Released by Next June

Army doctors are being released faster than the Army is reducing its total strength, in spite of the large number of battle casualties still remaining in hospitals and the requirement of doctors for separation center work, according to Major General Norman T. Kirk, Surgeon General of the Army, who spoke recently in New York in appreciation of the services rendered by member hospitals of the United Hospital Fund of New York.

"The peculiar situation that we find ourselves in is that demobilization, in which everyone is concerned, cannot proceed without the help of thousands of doctors—2,000 of whom are devoting their medical services solely to separation centers," General Kirk said. "By the first of January more than 14,000 doctors will have been returned to civilian life, which is more than one-third of the total number of doctors comprising the Army Medical Corps at its peak. By June of next year we anticipate releasing all but 11,000 doctors."

General Kirk, stating the peak hospital load in the United States to be 318,000, pointed out that there is still a need for medical personnel and that "one of our greatest problems is to hold enough doctors in the service to give the maximum medical care to our patients.

"I want to assure you," General Kirk concluded, "that, first, the Army Medical Department is going to continue to give to the sick and wounded soldiers of this war the best medical care known to science, and secondly, that it is going to return to civilian life as rapidly as possible every Medical Department officer whose services are not essential to the Army."

Army to Release 23 Hospitals by January 1

Release by the Army of 23 hospitals out of its wartime peak of 65 by January 1, 1946, has been announced by Major General Norman T. Kirk, the Surgeon General.

These hospitals will be offered to the Veterans' Administration or back to their former owners in the case of leased properties.

Additional hospitals will be released after the first of the year, but the schedule for such release cannot be forecast at this time, General Kirk declared. "As the number of men being cared for in any hospital decrease to the point where it is uneconomical to maintain it as a separate institution, the patients and facilities are consolidated into more efficient and workable units," he explained.

The peak patient load of hospitals in the United States, reached at the end of June, 1945, was 318,000, and has been dropping slowly ever since, despite the influx of men from overseas theaters, which was more than compensated for by hospital discharges.

The Medical Department estimated that by January 1, 1946, this total will have declined to about 220,000 patients, and that by June of 1947 there will be only 70,000 men remaining in Army hospitals.

Among hospitals to be released are the following:

DeWitt General Hospital, Auburn, California—December 31, 1945;

Hammond General Hospital, Modesto, California—December 21, 1945;

Hoff General Hospital, Santa Barbara, California—November 10, 1945;

Torney General Hospital, Palm Springs, California—November 10, 1945.

Army Specialized Training Program for Medical Students to be Liquidated

Medical students now in the Army Specialized Training Program, which is undergoing gradual liquidation, will continue training through the current fiscal year, ending June 30, 1946, with the future of the program depending upon requirements for medical officers, which will be reconsidered at that time, according to an announcement by the War Department.

Army Doctors Make Over One Million Physical Examinations During October

Over 1,250,000 physical examinations of Army officers and soldiers being demobilized in the United States were completed by Army doctors during October, according to Major General Norman T. Kirk, the Surgeon General.

The two thousand Army doctors assigned to separation centers alone completed examinations of 757,433 men during this preiod. In addition, Army doctors are assigned to other separation offices.

It is the policy of the Army, General Kirk said, to see that every man being released from the service is given the ultimate medical care before returning to civilian life. In addition, he pointed out, in order to speed demobilization, the complete physical examination has been so planned that the average soldier is processed by eight different doctors in one hour from the time the first doctor sees him, provided he has no ailment.

In this chain of medical examination he is looked over by a dentist, eye specialist, ear, nose and throat specialist, orthopedist, surgeon, urologist, and internist. Finally an overall medical officer, who has before him the reports of all preceding examinations, including all x-rays and laboratory tests, with the exception of serology, determines his physical condition. If it is necessary the man is referred to a ninth doctor—a psychiatrist.

Army Lowers Doctors' and Nurses' Score

Washington, Nov. 30.—(UP.)—The War Department today announced further reductions in the discharge score for Medical Department personnel. It said this would make an additional 15,000 physicians and 5,000 dentists eligible for discharge.

The discharge score for doctors and dentists was reduced from 80 points to 70. Also, they will become eligible for release after 42 months of honorable service or if they are 48 years of age to the nearest birthday.

The critical point score for nurses was cut from 35 to 25, and the discharge age from 35 to 30. Nurses now will be eligible for discharge after two years of service.

Those on duty in the United States classified for limited service also become eligible for discharge. It was estimated this would make 12,500 nurses eligible for discharge in addition to the 27,000 already qualified. Twenty-two thousand nurses have been discharged so far from the peak strength of 57,000.

Since V-E Day, 15,000 physicians and 3,500 dentists have been released. Peak Army strength was approximately 45,000 physicians and 15,000 dentists.—San Francisco *Chronicle*, December 1.

War Department Reports New Discharge Regulations

Washington, Nov. 30.—(AP.)—The War Department today announced discharge requirements for plastic surgeons, eye, ear and nose specialists, orthopedic surgeons and internal medicine specialists, will be eighty points or continuous service since Pearl Harbor. A requirement of seventy points or forty-five months' service is fixed for gastoenterologists, cardiologists, urologists and other specialists. . . .—San Francisco *Examiner*, November 30.

General Bradley Plan for Veterans' Hospitals is Supported

Washington, Dec. 2.—(UP.)—Major General Paul R. Hawley, acting Surgeon General of the Veterans' Administration and former Chief Army Surgeon in Europe, has threatened to quit—"and quit at once"—if Congress refuses to go along with General Omar N. Bradley's plans for veterans' hospitals, it was learned tonight.

Hawley wrote a blunt defense of Bradley's program to Representative Edith Nourse Rogers (R., Mass.) during last week's flareup over a $158,000,000 deficiency appropriation to build new veterans' hospitals.

The major fight is over Bradley's reluctance to take over surplus Army and Navy hospitals in the congressional constituencies. Hawley wrote Mrs. Rogers, member of the Committee on World War Veterans' Legislation, that it was impossible for General Bradley to operate most Army and Navy hospitals because they were so isolated that doctors are unobtainable.

"I, for one, will not experiment with the medical care of the veteran. Either he gets the quality of medical care that he deserves, or I quit."

He said that the Veterans' Administration now employs 2,327 doctors, only two-thirds of those it needs to man 71,000 existing beds. Three-fourths of these are medical officers subject to release from the service.—San Francisco *Chronicle*, December 3.

Military Clippings—Some news items of a military nature from the daily press follow:

"Give Us Back Our Doctors," Cries U. S.

(First of three articles on the discharge of doctors in the service by Frank Astom, Scripps Howard staff writer.)

Washington, Oct. 29.—Across the country the cry rises: "Give us back our doctors. Get them out of uniform. We are desperate. Suppose we had an epidemic."

The military responds: "In medicine, the war is not over."

Demand for speedier releases is expressed formally by the American Medical Association. It springs alike from civilians and from some uniformed doctors.

The Army and Navy say: "We are fully aware of civilian needs. We are releasing doctors as rapidly as we can."

Against this crowds a common charge: "It should have been faster."

The Army expects to discharge almost 17,000 by January 1, the Navy about 4,000. The services insist the pace of doctor dismissal is getting faster all the time.

"Not Fast Enough"

Civilians retort: "It still isn't fast enough."

The Army obtained about 45,000 men, the Navy about 13,000 from the 165,000 who were practicing in 1941. Both services asserted they never had enough doctors.

The medical services point proudly to their records:

In World War II, only four of every 1,000 battle wound cases died after reaching hospitalization. This was half the toll of World War I. The death rate from disease in World War II was 1.2 per 2,000 per year. This was a drop from 38 per 2,000 in World War I and from 130 in the Civil War.

But civilians argue: "The war is over. Release our doctors."

Since V-E Day, the Army has released about 7,000 doctors, the Navy about 1,000. Following V-J Day, both services set up a community hardship system to return critically needed practitioners. . . .

It takes about a month to complete a hardship discharge.

Complaints from doctors in service run to this effect: "I haven't anything to do. I'm forgetting what I knew about medicine. My hands are getting stiff. I'll have to take a refresher course before I resume practice."

The services comment: "Until about a month ago we did have a bottleneck of overseas medical men. But now they're returning in enormous numbers as we assign young replacements. We still need doctors to attend wounded and sick men and to serve at demobilization points. We will not neglect the men who won the war." . . .

The American Medical Association reports that it is sympathetic with the Army and Navy, but it contends that doctors should be demobilized more rapidly. The A.M.A. says it receives letters from members in uniform complaining about idleness and slow demobilization.

As the Association sees it, the demobilization trouble lies in faulty administration.

The Army and Navy maintain: "Our prime duty is to our wounded and sick. And the health of the rest of the men must be protected."

At the same time, the services conceded that some of their doctors may sometimes twiddle their thumbs for lack of medical practice.

* * *

The Army admits some of its doctors may be twiddling their thumbs at times. The Navy claims the physicians it retains are military necessities.

Both services report they are demobilizing doctors as rapidly as possible, consistent with safety to military health.

The American Medical Association says that isn't fast enough. The sentiment is echoed by various civilians and by many uniformed doctors.

6 to the 1,000

Here is the Navy's story:

"The Navy had 932 doctors before the war and 13,800 in July, 1945. We never had enough. By October 8, we had reduced our doctor count to 12,586.

"The Navy tried to provide three doctors for every 1,000 men. In combat that percentage was increased. By January 1 we expect to demobilize 4,000 doctors from the Naval Reserve. As of November 1 we are discharging doctors with 53 points.

"Wounded Navy men are still coming home from overseas. Some cases we dare not move. There will be a heavy patient load for some time. Moreover, we still have a good-sized personnel over whom doctors must keep medical watch.

"We shall discharge doctors as we discharge other personnel. We want to get our doctors back to civilian service as soon as possible.

"The Navy expects to have 3,000 to 4,000 doctors in its peacetime set-up."

Here is the Army's story:

"All Army doctors may not be fully employed today. Some are on duty with occupation forces. Some are on leave. Some who worked for Federal institutions have been discharged but cannot resume their work until their 45-day leaves expire because thye are not allowed to draw both Army and Government pay. Others are in the process of being reassigned. . . .

Navy's Story

"On the other hand, our front-line surgeons and physicians, particularly with the infantry, performed prodigiously. They operated and treated under incredible conditions and carried a back-breaking load. We tried to provide 6.5 doctors for every 1,000 men. But in most combat areas that would not have been enuogh.

"After fighting stopped, most overseas doctors were busy sending the wounded home. After most of the wounded had been returned, many of the doctors remained

abroad. But today they are coming back fast. Most occupation doctors complain that healthy men on police duty provide them too little practice. But the Army won't rob its men of medical protection. . . .

"The Army is exerting every effort to hurry doctors back to civilian service. Some may be cooling their heels on occupation duty and a few may have little to do while awaiting reassignments. But there is more than enough work for all of them."

To this the American Medical Association responds: "Demobilization of physicians should be faster. We feel that there is a weakness in the administrative system of the service."

* * *

The American Medical Association wants the Army and Navy to rush service doctors home.

The service took about 60,000 doctors from civilian life. That was almost one-third of the total number active in 1941. It meant that home-front physicians had to handle an increased amount of work. It meant also that civilian health was not always guarded adequately.

Army and Navy report they are doing all they can to speed release of doctors.

Ask Quicker Action

But the A.M.A. says:

"Our reports indicate the Army and Navy are not being as prompt as they might be. We feel that doctors should be returned more rapidly to improve civilian protection and lighten the burden of physicians who served at home.

"Our information is that too many service doctors are being held where they are not vitally needed. Doctors themselves report this. Many are eager to get back to work

"Men complain that they are in danger of losing their skill. A great number will insist on refresher courses. That would take time and deny medical service to civilians just that much longer." . . .

The Association's records show there were 201,272 physicians in this country at the outbreak of the war. All of these were not practicing at that time. The A.M.A. estimates about 165,000 were active in December, 1941. To help in the crisis, some old practitioners resumed, but the younger man carried most of the load. . . .

Thus civilians complain and the military explains. Inquiry into both sides reveals:

Some Are Idle

That here and there some military physicians are idle at times.

That demobilization slows down on occasion, leaving doctors and other service people temporarily stymied.

That the military refuses to discharge doctors at what it considers the peril of wounded or sick servicemen or of those to be demobilized.

That demobilization will require services of thousands of doctors well into next summer.

That, in medicine, the war is not over.—San Francisco *News*, October 31.

Colonel Lee, Out of Army, Crusades For Public Health

Calls Medical Corps Set-up "Antiquated"

Dr. Russel V. A. Lee, not yet out of uniform although he has received his discharge and arrived home on terminal leave, took time out yesterday from greeting former associates at the Palo Alto Clinic to blast the "unfortunately antiquated organization of the army medical corps." And at the same time praise the caliber of army doctors and the "wonderful preventative medicine program" developed during the war.

The Palo Alto physician, who has retired with the rank of colonel after three years in service, revealed that he had written the original proposal of the bill advocating the creation of a national department of health that will be introduced in the Senate later this month.

The bill calls for the establishment of the office of secretary of national health, who would have cabinet status, and of a Federal department that would coördinate all government health agencies.

"Public health, after all," said Dr. Lee, "is as important as the postoffice."

Dr. Lee's most recent assignment was in Washington, D. C., as chief of preventative medicine for the U. S. Army Air Forces. Under his direction the air corps developed the unit that sprays DDT, the insect killer, over large areas.

Flu Vaccine Developed

Also under Dr. Lee's direction was the first large scale experiment with the new influenza vaccine, which appears destined to place flu on the list of preventable diseases and gives new hope that other diseases caused by a virus also can be prevented at some future date. Infantile paralysis, he said, may fall into this class, as the virus that causes polio is very similar to the influenza virus.

"In Denver last summer we gave shots of the influenza virus to 20,000 air corps personnel. On the basis of the experiment's success the army as a whole is being immunized, starting October 1."

The DDT plane that sprayed Rockford, Ill., the city threatened with a polio epidemic early this fall, was from Dr. Lee's experimental unit. The disease dropped off, he said, but results, so far, are considered inconclusive. Planes also were used to spray a large area of the Panama Canal zone with the resulting death of 98 per cent of the mosquitoes in the area.

Dr. Lee's army experience was an enriching one, he said, but the great majority of army doctors were not so fortunate.

The doctors who volunteered to serve with high ideals of patriotism were bitterly disappointed in the out-of-date organization of the medical corps, and consider their years in service "a waste of time," he said.

"I do not mean any personal criticism of the surgeon general," explained Dr. Lee, "but definite revisions of the military organization should be carried out to prevent the waste of personnel that existed during the war.

"Army doctors on the whole are bitter and unhappy because they were not given enough medicine and were often placed in administrative jobs. No other groups is as anxious to get out of the army," he continued.

While the civilian population suffered from lack of medical care, there wasn't enough work to go around in the medical corps, Dr. Lee declared.

Civilians Neglected

"Except for battle wounds, it was much safer to be a soldier than a civilian during the war," he went on. The army, he claimed, had six and a half doctors for each 1,000 men, while civilians had but one doctor to each 1,700 persons.

"The medical corps apparently does not realize the potentialities of army transportation for doctors," said Dr. Lee. "The use of air travel would make it possible for doctors to be kept in a central pool and flown where they are wanted when they are needed."

Army reserve doctors show little desire to stay in the corps or even to keep up their reserve status, the surgeon said. He believes that the army will have to make immediate improvements to make the service more attractive, and suggested the following:

The providing of better professional opportunities by giving doctors more interesting work in large general hospitals.

More rank from the start and faster promotions. Dr. Lee pointed out that young medical graduates with eight years of study behind them are commissioned first lieutenants, while a surgeon whose private practice brings in $50,000 a year may be made only a captain or major.

Dr. Lee's army experience left him with a high opinion of the type of young doctor the medical universities are turning out today.—Palo Alto *Times*, October 12.

Establishment of Hospitals For Veterans

A Bulletin of the Veterans administration gives the following information:

1. The 19 hospital locations, which General Bradley, Administrator of Veterans' Affairs announced on October 18, 1945, are only a part of the program, and many new hospitals containing thousands of beds will be announced upon approval by the President.

2. The policy is to locate hospitals where the veterans will receive the maximum benefit from the most modern medicine and surgery of the type now available only to wealthy (or charity) patients at certain nationally known medical centers.

3. Generally speaking, the benefit received depends primarily upon the type of medicine provided and not upon the buildings housing the patients. First-rate medicine can be provided only by first-rate specialists.

4. There are insufficient top-flight specialists available to staff expanding Veterans' Administration hospitals. Therefore, the services of this limited number of men may be obtained on a part-time basis only and only at the places where they are available, which are near the leading teaching centers. These are where the new large veterans hospitals should be located if the maximum benefits are to be provided.

5. Much of this new policy results from the number of veterans being about five times as great as before

World War II. Where 4,000,000 veterans were potentially available before, there are now almost 20,000,000.

6. This requires the policy to be to bring the veterans to the hospital itself, reversing the World War I idea of bringing the hospital to the veterans.

7. This does not entail, however, the abandonment of existing hospitals or preclude the building of small local hospitals for the convenience of veterans and visiting families. It will provide a type of treatment which may well mean the difference between recovery or death for thousands of seriously ill or injured veterans.

8. The interests of the veterans themselves, rather than of communities desiring veterans hospitals required the adoption of the present policy.

9. As part of the program announced by General Bradley for the construction of 19 new Veterans' Administration hospitals with a total of 11,100 beds, 13 of these hospitals with 9,550 beds are located near medical schools.

Funds for the new hospitals and additions are being requested for the current fiscal year (1946). They are part of the overall 29,100 bed program approved by President Truman on August 4, 1945. The remainder of the program, which will be announced later, will be requested for the 1947 fiscal year.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Conference of Presidents and Other Officers of State Medical Societies

The first annual conference was held on Sunday, December 2, 1945, in the Tropical Room, Hotel Continental, Chicago.

PROGRAM

Presiding: A. S. Brunk, M.D., Detroit
Chairman of Presidents, Twenty-five States

2:30 P.M.

Report of Committee of Ten (Executive Commitee of Presidents, Twenty-five States)—H. H. Bauckus, M.D., Buffalo, N. Y., Secretary.

Presentation of Resolutions — Appointment of Committees.

3:00 P.M.

The Challenge—"How Can We Assure Adequate Health Service for All the People?"—Arthur J. Altmeyer, Washington, D. C., Chairman, Social Security Board.

How the Medical Profession Can Answer Today's Challenge—"Expansion of Voluntary Group Health Care Programs"—Joseph H. Howard, M.D., Bridgeport, Conn., President, Connecticut State Medical Society.

"Health Legislation Beneficial to the People"—Philip K. Gilman, M.D., San Anselmo, Calif., President, California Medical Association.

"Modern Medical Public Relations"—O. O. Miller, M.D., Louisville, Ky., Past-President, Kentucky State Medical Association.

"Formation of a National Health Congress"—John F. Hunt, Chicago, Ill., Vice-President, Foote, Cone & Belding.

5:00 P.M.

Round Table Discussion—Leader: E. J. McCormick, M.D., Toledo, Ohio, Past-President, Ohio State Medical Association.

Reports of Committees.

6:00 to 7:00 P.M.

Presidents' Reception—Host: The Michigan State Medical Society.

Acknowledgment: The California Medical Association and the Michigan State Medical Society for Joint Sponsorship of Program.

COMMITTEE ON PUBLIC RELATIONS

A.M.A. Public Relations Conference in Chicago

Specific recommendations for definite action resulted from the first A.M.A. Public Relations Conference held under the direction of the A.M.A. Council on Medical Service and Public Relations in Chicago October 19-20.

Developed along new lines, it was a sort of "grass roots" affair with 115 representatives registered from thirty-five states and the District of Columbia. A high point of the Conference, of course, was the talk by Major General Paul R. Hawley, Medical Director of the Veterans' Administration. Informal, frank, pointed, tied together with keen bits of midland humor, it left a fine impression. He has a tremendous job, but no one who heard him had any doubt as to his ability to tackle such a tough problem.

Following a quick getaway briefing by E. J. McCormick, M.D., chairman, on the first day, the Conference was streamlined to produce definite results into seven informal round table discussion groups under seven moderators. On the second day each moderator prepared a round-up report on each round table embodying definite recommendations to be worked up by the Council for presentation for action by the Board of Trustees and the House of Delegates of the A.M.A.

As soon as possible these recommendations will be published in *J.A.M.A.*

Definite recommendations were made in regard to:

1. Prepayment plans.
2. E.M.I.C. program.
3. Fourteen point program.
4. Placement of Returning Medical Officers.
5. Publicity and Public Relations.
6. Veterans' Administration.
7. Rural Health.

PREVIEW OF CONFERENCE RECOMMENDATIONS

On the Fourteen Point Program:

Note. The 14 Point A.M.A. Program appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1945, page 62.)

With reference to Point No. 1 relative to better living conditions, "We recommend constant publicity on the facts of this particular problem through the A.M.A., the state associations, the county societies, and the women's auxiliaries, by addresses and articles not only in the medical journals but also in the lay press."

For Point No. 2 concerning preventive medicine, "The implementing of this second point is by means of legislation. Such legislation should also be of interest to the A.P.H.A., the State and Territorial Health Officers Association, and the U.S.P.H.S. We recommend that the A.M.A. sponsor a conference with these groups in an endeavor to enlist their coöperation in legislative efforts to accomplish the purpose of this item."

"And on Point 14 referring to Veterans' Administration and U. S. Public Health Service, "Free choice of physician for all veterans under the care of the Veterans' Administration and integration into the voluntary plans of hospitalization and medical care."

On the E.M.I.C. Program:

"That the present Medical Advisory Committee to the Children's Bureau is not truly representative of the entire medical profession. Any program of that Bureau must be administered through the States' Medical Associations, and they should be represented."

"That the present advisory steering committee to the Children's Bureau be abolished and a new committee be

established which shall consist of one representative from each state medical association . . . and such other medical organizations as have a direct interest in the functioning of the Bureau."

"That since the Children's Bureau is not properly related to the Department of Labor, it should be transferred to the Federal Security Agency until such time as all health and medical activities of the Government are segregated into a single department."

On the Placement of Medical Officers:

"That all discharged medical officers be given terminal leave pay at the termination of their active duty and prior to the expiration of such accrued leave as they may have, thus enabling them to participate immediately in the benefits provided by Public Law 346 (78th Congress, G. I. Bill of Rights). Such a procedure will enable the returned medical officer to commence immediately his training in hospitals or medical schools after leaving the armed services."

"It is recommended that the Council on Medical Education and Hospitals be urged to set up at once a method for the more prompt approval of hospitals for residencies and consider the advisability of giving some temporary approval until formal inspections can be made."

* * *

A.M.A. Advisory Committee on Prepayment Medical Care Plans:

The Council has approved the appointment of an Advisory Committee to direct the work on Prepayment Medical Care Plans. The Committee will be composed of various plan directors and others interested in this problem. It will have the duty of setting up a program for gathering regular monthly or quarterly data on the plans; for analyzing such data, and reporting back to the plans or to medical societies interested in starting plans. An organization meeting will be held at the A.M.A. headquarters at the earliest possible date.

* * *

Health Council Plans on Local Level:

The Community Health Council idea as a medium for public relations and to assist in activating health programs seems to have a promising future. Until recently Health Councils have generally been local medical society projects. Dr. John Fitzgibbon has emphasized the importance of such Councils in the statement: "Most public health problems could be satisfactorily solved at the local level if local medical societies would assume the leadership in a plan of coöperative effort with other interested local organizations and agencies with whose leaders friendly relations were easily made or already existent."

Another program just instituted, and which presents a different and interesting approach to the problem, is that of the Michigan Health Council. This is not an effort solely by the doctors of Michigan but represents the combination and coördination of their influence and support with that of other organizations of the state which have a common interest. The Council was incorporated a year ago as a joint organization of the Michigan State Medical Society, the Michigan Hospital Association, Michigan Service and Michigan Hospital Service.

Reports on Proposed Laws Related to Public Health Activities

A report upon certain bills now pending before Congress.

Wagner-Murray-Dingell Bill—S. 1050:

The Senate bill is still with the Committee on Finance while the House bill is with the Committee on Ways and Means. Neither Committee has manifested any intention of early consideration of the bills, but Senator Wagner says he expects to have hearings upon his bill held in the near future.

Hill-Burton Hospital Bill—S. 191:

The subcommittee of the Senate Committee on Labor and Education has rewritten S. 191 and reported it out to the Full Committee a week ago. Today the Full Committee reported it to the floor of the Senate. Among the important features of the bill are—

1. Instead of appropriating $100,000,000 for construction for the fiscal year ending June 30, 1946, the new bill provides $75,000,000 each year for the first five years beginning the fiscal year of 1947.

2. The formula for allotment to states has been changed so that allotments will range from 33 1/3 per cent to the most wealthy states to 75 per cent for the poorest.

3. The Surgeon General is instructed to prepare within six months, with the approval of the Federal Advisory Council and the Administrator, general regulations with regard to the

a. Number of general hospital beds that may be constructed in any specific area.
b. Specialized hospital beds.
c. Number and distribution of public health centers.
d. General manner of determining priority of projects.
e. General standards of construction and equipment.
f. Prevention of discrimination on account of race, creed or color.

4. Ten specific instructions are outlined for preparation of plans by the States. Briefly stated they are:

a. Designate a single agency to administer or supervise administration of the plan.
b. Show that this agency will have authority to carry out the plan.
c. Provide for an advisory council to consult with the agency.
d. Set forth a hospital construction program to be based on a survey of needs.
e. Set forth the relative need for projects and provide for their construction.
f. Provide methods of administering the plan.
g. Provide minimum standards for maintenance and operation of hospitals which receive Federal aid under this title.
h. Provide for an opportunity for a hearing before the agency to every applicant for a construction project.
i. Provide that the agency make such reports from time to time as the Surgeon General may require and give him, upon demand, access to the records upon which such information is based.
j. Provide that the agency will from time to time review its hospital construction program and submit to the Surgeon General modifications it deems necessary.

5. The definition of public health center is modified by limiting it to the provision of "public health services." The original bill had provided "medical care" as well.

National Research Foundation Bill—S. 1297, S. 1285 and S. 1248:

The three Senate bills, S. 1297, S. 1285 and S. 1248 authorizing the creation and financial support by the Federal Government of a national research foundation are being considered by the subcommittee of the Committee on Military Affairs. Hearings have been held. Members of the subcommittee are Senators Kilgore, West Virginia, Chairman; Thomas, Utah; Johnson, Colorado; Murray, Montana; Revercomb, West Virginia; Wilson, Iowa.

Dr. Vannevar Bush whose report—"Science, the Endless Frontier" formed a basis of the bill, was a witness. That the Government should stimulate research and assist with appropriations is unanimously agreed, but there is a difference of opinion as to how the Government shall be related to the work. Some recommend that there be created by the President a board of prominent scientists who shall select a director, but he shall not have the

power of veto. Others recommend that the President appoint a director and a board, giving the director full authority. Still others suggest that there shall be two boards, a scientific board and an administrative board, and the director should be over the administrative board. Difficulty in separating fundamental, basic or curiosity scientific research from applied scientific research complicates the problem of administration.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

County Hospitals in California May Admit Veterans Eligible for U. S. Care

County hospitals may admit veterans with nonservice connected disabiliteis who are also eligible for care in a Veterans Administration hospital, according to a recent opinion of the Attorney General.

The opinion was prepared for the Kern County Counsel who had inquired concerning the admissibility to the County Hospital of veterans with tuberculosis who are residents of the county but who have available to them adequate medical treatment and hospitalization from the Federal Government.

"The right to receive care at a veterans hospital is not in our opinion a property right," the Attorney General stated. "At least it is not such a right as would prohibit or deny admission to the applicant otherwise qualified for the county hospital."

California Hospital Advisory Board

Dr. John C. Sharp, medical superintendent of Monterey County Hospital, is chairman of the Hospital Advisory Board, appointed by Governor Earl Warren to assist the State Department of Public Health in the administration of the New Hospital Act.

Serving with Dr. Sharp are: Dr. Charles R. Poitevin, administrator of Long Beach Osteopathic Hospital; Mr. Charles A. Wordell, administrator of San Francisco Children's Hospital; Mr. Paul T. Elliott of Los Angeles Presbyterian Hospital; Mr. A. A. Aita, administrator of San Antonio Community Hospital in Upland.

Accidental Death Rate Called Low at Los Angeles County Hospital

Official Testifies County Institution's Record of Fatalities Is Below Average

"Los Angeles County General Hospital has fewer 'accidental' deaths due to improper treatment or the administration of wrong medicine than the average hospital," Dr. Pheobus Berman, director of the medical unit at the institution, on November 7, told an Assembly committee.

"During my 26 years at the hospital, I do recall some accidental deaths, but they occur in every hospital," he said.

Public Hearing

His testimony was given before the Assembly interim committee on charitable institutions, which is holding a public hearing in the State Building on conditions at the hospital. The inquiry is the result of the recent "wrong bottle" death of 14-year-old Pauline Estrada, in the Osteopathic Unit of the Los Angeles County General Hospital.

"More than 600,000 patients are treated in General Hospital annually," Dr. Berman pointed out, "and out of that number some, naturally, are dissatisfied with their medical treatment or the services they are given by hospital attendants.

"But the majority of the patients and their families are satisfied—those are the ones from whom you hear no complaints. In fact, we have a large file of letters from ex-patients praising the hospital." . . .—Los Angeles *Times*, November 8.

Statement of Advisory Committee of Los Angeles General Hospital

In a letter received yesterday by the Board of Supervisors, signed by A. B. Ruddock, chairman of the committee, the following is set forth:

"The General Hospital Advisory Committee has closely followed the circumstances surrounding the recent death of Pauline Estrada in the osteopathic unit of the General Hospital. Members of the committee have inspected the facilities and installations where the regrettable incident occurred and have reviewed the manuals covering medical and nursing procedures in the hospital. The committee has also surveyed the situation with representatives of the staff and the County Medical Association.

"The facts elicited by this investigation serve only to confirm the heretofore held opinion of your committee that this large hospital, with its multiplicity of services, is being well operated. Your committee has full confidence in the administrative officers of the hospital, Mr. Arthur J. Will and Mr. Leroy Bruce. It feels that this unfortunate death cannot be attributed to any failure, or error, on the part of these officers."

Besides Chairman Ruddock other members of the lay committee are: J. C. MacFarland, Maynard McFie, Dr. Robert A. Millikan, Roy E. Naftzger, Mrs. Rollin Brown and Garner A. Beckett.—Los Angeles *Times*, November 3.

Los Angeles County General Hospital Has a Good Record

Recent statements by Albert B. Ruddock, chairman of the General Hospital Advisory Committee, and by the Los Angeles County Medical Association appear to indicate that much recent criticism of the General Hospital lacks justification. While it is undeniable that in the General Hospital, occasional mistakes have been made both by doctors and nurses which have resulted in death or injury of patients, these errors appear to bear a very small proportion to the number of patients treated.

Mistakes occur in private hospitals and in private practice also. The General Hospital is a very large institution, treating some 2,800 patients daily, and in the course of a year millions of treatments of all sorts are administered. While it is regrettable that any mistakes should occur, it is hardly humanly possible to eliminate all of them. The best of systems will slip up at times, since all humans are fallible.

The hospital is understaffed, both with doctors and with nurses, but this is largely due to conditions beyond the control of the management or anyone else. In the allocation of doctors and nurses the armed forces have had to come first. The opinion of the County Medical Association that the record of the General Hospital is, in view of all factors, excellent and compares favorably with that of private hospitals is entitled to much weight. —Editorial in Los Angeles *Times*, November 10.

Rates Up at Two San Francisco Hospitals

Two San Francisco hospitals on November 16, boosted rates to meet rising prices and the San Francisco Hospital Conference, representing all but four of the city's hospitals, was "discussing the issue."

Charles J. Malinowski, president of the conference, said

rate boosts have been "under discussion for some time," but the conference has not yet been acted officially."

Two members of the conference, Franklin and St. Lukes hospitals, have acted independently to raise rates.

Superintendent Malinowski, of the French Hospital, said there was "a definite need for increases, in room and board rates."

Increases in food prices have left some hospitals "selling way below cost," he said.

The conference embraces all but Chinese, Sutter, Morton and San Francisco County hospitals.

At Franklin Hospital, rate increases applied to rooms, including board, but did not effect operating room and other fees, it was said.

Court Holds French Hospital of San Francisco Not Charitable Institution

In a broad ruling affecting hospitals operated by mutual benefit societies, the United States Circuit Court of Appeals here on Dec. 5 ruled that the French Hospital is not a charitable institution and must, therefore, pay Social Security taxes.

The Circuit Court reversed a ruling by Federal District Judge A. F. St. Sure who held that the hospital, operated by La Societe Francaise de Bienfaisance Mutuelle, was not liable for such taxes. Judge St. Sure ordered the United States Collector of Internal Revenue to refund $35,269 in taxes paid for the years 1936 to 1939.

Because members of the society, who pay a monthly rate to cover medical care, benefit through lower rates, the Circuit Court ruled that the hospital could not be classified as an organization "operated exclusively for charity."

The court's opinion pointed out that more than half of the hospital's 1944 income of $680,448 came from patients who were not members of the society.—San Francisco *Examiner,* December 6.

French Hospital of San Francisco Loses U. S. Tax Case

A long-pending dispute as to whether French Hospital was a charitable institution and therefore not obligated to pay social security taxes yesterday was decided by the U. S. Circuit Court of Appeals against the hospital.

An opinion of the Court, written by Judge William E. Orr, held "the hospital is not charitable in any sense" although citing that a large part of the hospital's services went to members of the French Mutual Benefit Society for a monthly assessment of $1.75.

By the ruling, the hospital is obligated to turn over to the Internal Revenue Collector $35,269 paid under protest in social security taxes for the years 1936 to 1941. Previously, Federal Judge St. Sure and a deputy revenue collector had ruled in favor of the hospital.

Judge Orr's opinion described the membership hospital service as "low cost" rather than charitable, and cited additionally that non-members paid regular hospital rates. —San Francisco *Chronicle,* December 6.

Veterans' Hospital Facilities in California

California Sends Appeal to Truman For 8,000 More Beds

"Totally inadequate" hospital facilities for disabled World War II veterans in California were described in detail on November 16, by a Senate interim committee which demanded immediate provisions for 3,000 additional beds in Northern California and 5,000 in Southern California.

The demand was in the form of a resolution adopted by the interim committee on veterans' affairs, headed by State Senator Irwin T. Quinn. It is being forwarded to President Truman, General Omar N. Bradley, director of the Veterans' Administration, the Federal Board of Hospitalization and all members of California's congressional delegation.

The resolution asks that the 8,000 additional hospital beds for veterans in this State be actually divided between general and surgical cases, with adequate provisions for treatment of recurrent tropical diseases, for nervous and mental disorders and for tuberculosis and other respiratory cases.

Hospital needs, the resolution states, were determined from "factual evidence" presented at a hearing held in San Francisco on November 5 and in Los Angeles, November 7. The evidence showed, it continued, that on December 7, 1941, all veterans' hospital facilities were filled to capacity and that since then only 250 beds have been added.

It said California's requirements for rehabilitation of veterans, with 700,000 men inducted from this State and another 350,000 discharged veterans from other states now here, will be more than 33 1/3 per cent above normal.

"A most critical situation now confronts the Veterans' Administration," it declared, "and new facilities and beds must be immediately provided in California to prevent chaos and a breakdown in caring for those who come back from the battlefronts sick, disabled and broken in health."

It called upon the Veterans' Administration to take over Army and Navy hospitals that are being closed, and to allocate some of its $500,000,000 for new hospitals to California.

"Hospital Construction and Survey Bill" Endorsed by American Hospital Association

Legislation which would enable the Federal Government to promote the building of hospitals where they are needed as indicated by thorough surveys of state and local needs was introduced early in 1945 into the 79th Congress as the Hospital Construction and Survey Act, Senate Bill S. 191, and is aggressively supported by the American Hospital Association in conjunction with other national health and labor organizations. Several companion bills are also before the House. (The Council of the California Medical Association has at two meetings, approved S. 191.)

These identical bills propose survey and building programs to be administered by state governmental authorities under the general supervision of the Surgeon General of the U. S. Public Health Service, who will be aided by a Federal Advisory Council. S. 191 proposes Federal grants-in-aid for three purposes: to inventory existing hospitals and health centers and to survey the need for additional construction; to recommend construction of public and nonprofit hospitals and health centers that would supplement existing hospitals, clinics and similar services; and thirdly, to aid in the construction of hospitals and health centers in accordance with the needs indicated by such surveys.

The Bill's authorization for appropriation for the first year totals $750,000,000 with a like amount to be supplied by state and local funds. Hearings before the Senate Committee on Education and Labor were completed in March, and hearings before the House Committee will be opened on November 15. In contrast to the previously established Federal works system which built hospitals without benefit of thorough surveys, S. 191 proposes to build hospitals where they are most necessary and to allot funds according to the relative financial needs of the various states.

COMMITTE ON POSTGRADUATE ACTIVITIES

U. C. Refresher Course in Psychiatry Scheduled

A twelve-weeks refresher course in psychiatry will be offered by the Division of Psychiatry with the help of other divisions of the Medical School of the University of California. The announcement comes from Dr. Karl M. Bowman, director of Langley Porter Clinic on the San Francisco campus, who is in charge of the instruction.

Designed for returning service men who wish to prepare for examinations of the American Board of Psychiatry and Neurology, the course will start on January 7 and will consist of 420 hours of lectures and clinical demonstrations. The enrollment is limited to fifty and only graduate physicians are eligible who have had some experience in psychiatry, but candidates also will be judged on the basis of individual qualifications. Arrangements for the class are being handled by University Extension.

There is a definite shortage of trained psychiatrists, Dr. Bowman says. Only 4,500 psychiatrists are registered in the United States whereas a conservative estimate places the need at more than 10,000.

Medical Research Fund Gives $40,000 to U.C.L.A.

A gift of $40,000 from the Jewish Fund for Medical Research was recently received at the Los Angeles campus of the University of California. This sum is to be devoted to the furtherance of cancer research at that campus, Dr. Robert Gordon Sproul, University president, announced.

The University has already received one-half of the sum and the remainder will be made available in the near future. It will bring to $50,000 the total amount given to the University by the national fund.

Part of the funds, which were obtained largely through the efforts of David Tratner, Los Angeles merchant, will be used for a special building on the Los Angeles campus. It will be designed to facilitate expanson of a cancer research project already in progress.

Dr. Harry S. Penn, research associate in zoology, who is directing the work, has already pronounced results "encouraging" in this vital investigation of one of the principal mortality causes in the United States today.

A committee of scientists drawn from the Berkeley campus as well as the Los Angeles campus of the University has been appointed by Dr. Sproul. Zoology professor, Dr. Albert W. Bellamy, is in charge of the committee.

Twelfth Annual Postgraduate Assembly—College of Medical Evangelists

The Twelfth Annual Postgraduate Assembly was held Sunday, December 2, 1945, from nine o'clock in the morning until nine-thirty o'clock in the evening in Paulson Hall, at the White Memorial Hospital, 1819 Michigan Ave., Los Angeles.

All medical men in good standing were invited to register and attend the Assembly. The registration fee was three dollars. Residents, interns, and medical students were guests of the Alumni Association.

PROGRAM

9:00 a.m.—"The Examination of Low Back Pain."
Joseph C. Risser, M.D., Clinical Professor of Orthopedics, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

9:30 a.m.—"Ten Million Deafened."
Russell M. Decker, M.D., Assistant Clinical Professor of Surgery (Otolaryngology), University of Southern California School of Medicine, Los Angeles, Calif. (Followed by film—"The Right to Hear.")

10:00 a.m.—"Amebic Hepatitis and Liver Abscess."
A. C. Pattison, M.D., Assistant Professor of Surgery, University of Southern California School of Medicine, Los Angeles, Calif.

10:30 a.m.—"The Importance of Early Diagnosis in Rheumatic Fever."
Louis E. Martin, M.D., Assistant Clinical Professor of Medicine, University of Southern California, School of Medicine, Los Angeles, Calif.

11:15 a.m.—"Remarks on Diagnosis of Brain Tumors."
Carl Rand, M.D., Professor of Neurosurgery, University of Southern California School of Medicine, Los Angeles, Calif.

11:45 a.m.—"The Use of Artificially Radioactivated Elements in Diagnosis and Therapy."
Bertram V. A. Low-Beer, M.D., Assistant Professor of Radiology, University of California School of Medicine, San Francisco, Calif.

12:15 p.m.—"The Diagnosis of Allergic Rhinitis and Asthma."
William C. Deamer, M.D., Associate Professor of Pediatrics, University of California School of Medicine, San Francisco, Calif.

2:00 p.m.—"Management of Carcinoma of the Lower Bowel."
William H. Daniel, M.D., Associate Clinical Professor of Surgery, University of Southern California Medical School, Los Angeles, Calif.

2:30 p.m.—"Interpretation of Intravenous Urograms."
James R. Dillon, M.D., Clinical Professor of Urology, Stanford University School of Medicine, San Francisco, Calif.

3:00 p.m.—"Laboratory Aids in Diagnosis of Endocrine Disorders."
Leo T. Samuels, Ph.D., Head of Department of Biochemistry, University of Utah Medical School, Salt Lake City, Utah.

3:30 p.m.—"Applications for Invisible Plastic Contact Eye Lenses."
Harold F. Whalman, M.D., Clinical Professor of Ophthalmology, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

4:15 p.m.—"Plastic Surgery on the Extremities."
Lt. Comdr. W. John Pangman (MC), USNR, Plastic Surgery Departmetn, U. S. Naval Hospital, Oakland, Calif.

4:45 p.m.—"Office Treatment of Diabetes Mellitus."
Solomon Strouse, M.D., Clinical Professor of Medicine, University of Southern California School of Medicine, Los Angeles, Calif.

5:15 p.m.—"The Changing Picture in Tuberculosis."
Edward Kupka, M.D., La Vina Sanitarium, Altadena, Calif.

7:00 p.m.—"Mental Patients' Attitudes to Their Own Life Histories."
Karl L. Buhler, M.D. (Freiburg), Ph.D., Psychologist at the Veterans' Administration, Los Angeles, Calif.

7:30 p.m.—"Cutaneous Ulcerative Hodgkin's Disease and Tissue Imprints."
Louis H. Winer, M.D., formerly Clinical Associate Professor of Dermatology of University of Minnesota, Minneapolis, Minn.

8:00 p.m.—"The Electron Microscope—Its Significance in Research."
Newton Evans, M.D., Professor of Pathology, College of Medical Evangelists School of Medicine, Los Angeles, Calif.

8:30 p.m.—"The Art, Science, and Business of Medicine." W. B. Holden, M.D.

* * *

The College of Medical Evangelists on November 29, presented the first annual Newton Evans Lecture in Bacteriology and Pathology. Speaker: Wesley W. Spink, M.D., Department of Medicine, University of Minnesota Medical School. Subject—Brucellosis: Diagnostic and Therapeutic Considerations.

Fifteenth Mid-Winter Convention—Postgraduate Clinical Convention

The Research Study Club of Los Angeles (Eye, Ear, Nose and Throat) has issued its brochure announcing the Fifteenth Annual Mid-Winter Postgraduate Clinical Convention in Ophthalomology and Otolaryngology to be held from January 21 to February 1, inclusive, 1946. There will be the Special Course in "Applied Anatomy and Cadaver Surgery of the Head and Neck," which will be given from February 1 to 5, inclusive. This schedule is so arranged that the Special Cadaver Course cannot interfere with the regular Clinical Convention.

The endeavor is to make the Convention essentially practical; to bring up ideas which the members may take home to utilize in their everyday practice, as well as to stimulate their interest in research studies. The teaching staff will include:

Alan C. Woods, M.D., Professor of Ophthalmology, Johns Hopkins Medical School, and Director, Wilmer Ophthalmologic Institute, Baltimore, Maryland.

Jack S. Guyton, M.D., Associate Professor, Wilmer Ophthalmologic Institute, Baltimore, Maryland.

O. E. Van Alyea, M.D., Associate Professor of Otolaryngology, University of Illinois, Chicago,

Richard Waldapfel, M.D., former Associate Professor, Vienna University, Vienna, Austria. Residence, Grand Junction, Colorado.

Samuel Fomon, M.D., New York City, New York.

Charles E. Kinney, M.D., Lecturer, Graduate School, Western Reserve University, Cleveland, Ohio.

William J. Kerr, M.D., Professor of Medicine, University of California, San Francisco, California.

Herbert M. Evans, M.D., Professor of Biology, University of California, Berkeley, California.

Vern O. Knudsen, Ph.D., Professor of Physics and Dean of Postgraduate School, University of California, Los Angeles, California.

Samuel Salinger, M.D., Clinical Professor of Otolaryngology, Loyola University School of Medicine, Chicago, Illinois.

Meyer Wiener, M.D., Professor of Ophthalmic Surgery, Washington University, Saint Louis, Missouri. Residence, Coronado, California.

Frederick C. Cordes, M.D., Professor of Ophthalmology, University of California, San Francisco, California, and member of the Board of Editors of the American Journal of Ophthalmology, and of the Quarterly Review of Ophthalmology.

Irving B. Lueck, M.S., Rochester, N. Y.

Alvin G. Foord, M.D., Associate Professor of Clinical Pathology, University of Southern California, Los Angeles, California. Residence, Pasadena, California.

Aubrey G. Rawlins, M.D., San Francisco, California.

Samuel A. Crooks, M.D., Professor of Anatomy, College of Medical Evangelists, Loma Linda, California.

William H. Johnston, M.D., Santa Barbara, California.

Simon Jesberg, M.D., Los Angeles, California.

Isaac H. Jones, M.D., Los Angeles, California.

Gilbert Roy Owen, M.D., Los Angeles, California.

J. Raymond Brown, B.S., Los Angeles, California.

For additional information, address Pierre Violé, M.D., 1930 Wilshire Boulevard, Los Angeles, 5.

The American Laryngological Rhinological and Otological Society—Western Section

Saturday, January 26, 1946

Elks Club

The Western Section of the American Laryngological, Rhinological and Otological Society will hold its meeting at the Elks Club in Los Angeles on January 26 and 27, 1946. All members of the profession, whether or not they are members of the Society, are invited to attend.

2:00 P.M.

1. Introduction of the President, Albert C. Furstenberg, M.D., Ann Arbor, Michigan.
2. "Indications for the Fenestration Operation"—Howard P. House, M.D., Los Angeles, California. Discussion: Robert C. Martin, M.D., San Francisco, California.
3. "Schwannoma (Neurileoma) of the Pharynx with Horner's Syndrome"—Pierre Violé, M.D., Los Angeles, California. Discussion: Emil Tholen, M.D., Los Angeles, California.
4. "Frontal Sinusitis"—J. Mackenzie Brown, M.D., Los Angeles, California. Discussion: O. E. Van Alyea, M.D., Chicago, Illinois.

Sunday, January 27, 1946

Elks Club

9:15 A.M.

5. Business Meeting

10:00 A.M.

6. "Two Interesting Cases of Foreign Body of the Esophagus"—Arthur C. Jones, M.D., Boise, Idaho. Discussion: Simon Jesberg, M.D., Los Angeles, California.
7. "Otolaryngological Problems in Acute Rheumatic Fever"—David Higbee, M.D., San Diego, California. Discussion: Comdr. Joseph B. Stevens, MC, USNR.
8. "Measurement of the Overflow Capacity of the Maxillary Sinus and Its Significance." Ben R. Dysart, M.D., Pasadena, California. Discussion: Samuel Salinger, M.D., Chicago, Illinois.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

J.A.M.A. Comments on President Truman's Health Insurance Plan*

THE NATIONAL HEALTH PROGRAM—THE PRESIDENT'S MESSAGE

In the Organization Section of this issue of *The Journal* appears the complete text of the message of President Harry S. Truman to the Congress, delivered on November 19. The text was received as *The Journal* was going to press. The President presents a five point program. The measures proposed by the Hill-Burton bill for increased funds for hospitals and health centers throughout the nation are covered by his first point. The American Medical Association has approved the principles of the Hill-Burton bill subject to safeguards which are in the text reported by the committee which conducted hearings on this measure.

The second recommendation of the President is for expanded maternal and child health services—essentially those proposed by the Pepper bill. It should be apparent that the passing of a nationwide compulsory sickness insurance bill ought to make unnecessary the kind of proposals included under the Pepper Maternal and Child Health measure.

The President urges increased funds for medical education to be given to public and nonprofit institutions for extending medical education and particularly for research in the fields of cancer and mental health. Obviously this proposal is duplicated to some extent by the proposals for the National Science Foundation. This proposal would place the Federal Government definitely in control of

* For editorial comment, see pages 259-264. Also p. 309.

medical education throughout the United States through its ability to allocate funds to medical educational institutions.

The fourth proposal is for a nationwide system of compulsory sickness insurance to cover every man, woman and child in the United States and to care for the indigent through insurance policies purchased by local agencies for which they would be reimbursed in whole or in part by the Federal Government. The American Medical Association has opposed compulsory sickness insurance consistently for many years. The President reaffirms Senator Wagner's peculiar interpretation of the term socialized medicine by claiming that "this is not socialized medicine." The affirmation will not be convincing to the physicians of the United States who would be compelled to submit to politically controlled medicine should such a measure ever become the law of the nation.

Finally, the President urges compensation of workers for disability due to illness. The House of Delegates of the American Medical Association has approved such proposals in the past.

Fortunately the House of Delegates of the American Medical Association is scheduled for a session to be held in Chicago, December 2-6. The House of Delegates will no doubt at that time state officially the point of view of the American Medical Association on the President's proposals.—*J.A.M.A.*, November 24, 1945.

5-Point Health Plan Offered By President Truman

Compulsory U. S. Hospital, Disability Insurance, Aid to Mothers Recommended

President Denies Proposal Is "Socialized Medicine," Says It Will Help Bring Freedom From Want, Boost Production

Washington, Nov. 19.—President Truman today proposad a broad five-point national health program, recommending that Congress adopt a compulsory national health insurance system for the prepayment of medical costs. Stressing that what he was recommending was "not socialized medicine," the President set forth his program in a lengthy message to the House and Senate.

Mr. Truman's basic recommendations for legislative action were:

1. Federal aid for construction of hospitals, health centers and other facilities where they are needed.

2. Increased use of Federal funds to expand coöperative state-Federal public health, maternal and child health service.

3. Federal aid to support more adequate professional education and the advancement of research on the cause, prevention and cure of cancer and mental illnesses.

4. A compulsory national health insurance system to assure prepayment of medical costs under a plan which would leave patients free to choose their own doctors and hospitals.

5. Disability insurance for protection against loss of wages because of sickness and disability.

Increased Production

The President urged Congress to give careful consideration to his program now. The nation's economic productivity, he said, will increase in direct ratio to improvement in the national health.

"Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available," the President said.

"By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land."

The President, saying that all American citizens should have ready access to all necessary medical and hospital services, recommended that the basic problem involved be solved by distributing the costs through expansion of the existing compulsory social security insurance system.

U. S. Health Fund

Mr. Truman proposed compulsory health insurance which would cover medical, hospital, nursing and laboratory services, and dental care.

His plan would call for establishment of a national health fund which he said would assure adequate support for doctors and hospitals everywhere.

He proposed that the nationwide system be highly decentralized in its administration with local administrative units adapting local services to local needs and conditions.

Subject to national standards, methods and rates of paying doctors and hospitals would be adjusted locally, and these rates would be adjusted upward for qualified specialists.

Repeatedly emphasizing that his plan would not amount to socailized medicine, the President said the people should remain free to choose their own doctors and hospitals. Removal of financial barriers between the patient and the doctor he asserted, "would enlarge the present freedom of choice."

The legal requirement that the people would have to contribute to the program would not, the President emphasized, affect the doctors' freedom to decide what services their patients needed.

At the same time, he added, the people would remain free to obtain and pay for medical services outside the health insurance system just as they are now free to send their children to private instead of tax-supported schools. —San Francisco *News*, November 19.

U. S. Chamber of Commerce Takes Stand On Compulsory Insurance

The Chamber of Commerce of the United States has taken a definite stand on compulsory health insurance and has circularized its members with a copy of President Truman's message on the subject.

By a referendum vote of its organization members, the chamber has established a policy on medical and cash sickness benefits which is as follows:

"Employers who have not done so should explore the possibility of providing for their employees some protection against non-industrial or non-occupational disabilities and sickness.

"If, after a reasonable period of time, the private effort of employers to provide protection against non-industrial and non-occupational disabilities and sickness still leaves substantial gaps in coverage, only then should public action be taken.

"If such public action as indicated in Declaration No. 17, this should be at the state and local levels of government rather than at the Federal level.

"If such legislation as indicated in No. 17 is passed, this should permit voluntary group plans to operate as alternatives to government plans.

"Voluntary group effort to provide more adequate medical services for all the people is urged.

"There should be avoidance of a system of socialized medicine, under which all the medical personnel become government employees and the free choice of doctor by the patient and of patient by the doctor is impaired."—San Francisco *Daily Commercial News*, November 30.

A.M.A. Policy-Makers Denounce President Truman's Health Plan

Chicago, Dec. 5.—(UP.)—The American Medical Association's policy-making House of Delegates was on

record today with official disapproval of President Truman's proposed national health program.

In the only closed session of the annual meeting, delegates last night denounced the President's tax-supported health insurance proposal as "the first step in a plan for general socialization, not only of the medical profession, but of all professions, industry and labor."

After the meeting, the A.M.A. policy group said in a statement that voluntary prepayment medical plans now in operation in 24 states would achieve all the objects of Mr. Truman's program, as embodied in the Wagner-Murray-Dingell bill, and provide "the highest type of medical service without regimentation."

The statement charged that the Senate measure was "founded on a false assumption that solution of the medical care problem for the American people is the panacea for all their troubles of the needy."

The House of Delegates approved, however, sections of the President's proposal which recommended Federal aid for building health centers and developing a national research foundation.

Sections of the proposal favoring extension of maternal and child care services and compensation for loss of earnings due to sickness were referred back to the public relations and legislation committee for further consideration.

The delegates, representing more than 125,000 American physicians, voted to support the Magnusen bill, which would place a research foundation under a professional, non-governmental scientific board, rather than under one person appointed by the President.

Opposition to the insurance provisions of President Truman's health proposal also was expressed, on the grounds that the program would be "enormously expensive" and would result in increased taxation "for the entire population of the United States."

The delegates also recommended the immediate discharge of all medical officers in the armed services, and approved an offer by the American Red Cross to turn over for use by the civilian population all plasma accumulated from the War and Navy Departments.—San Francisco *News*, December 5.

Medical Association Backs Voluntary Prepaid Plans

Chicago, Dec. 5.—(AP.)—The American Medical Association gave the green light today to a program designed to establish a nationwide network of "voluntary" prepayment medical plans, to be sponsored by medical societies.

The Association, through its House of Delegates, took action after branding as "socialized medicine" a proposal by President Truman for a Federal system of sickness insurance.

The Association's board of trustees and its council on medical service and public relations were instructed "to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by the medical societies."

"This is the go-ahead signal we've been awaiting for a long time," said Dr. Edward J. McCormick of Toledo, Ohio, chairman of the council.

Voluntary Plans

"The A.M.A. for several years has sponsored extensive studies of existing prepayment plans and has favored the extension of these as much as possible, but we now have an actual directive to promote the establishment of voluntary plans to cover the whole nation."

Declaring that 47 voluntary plans—sponsored by physicians—now are in operation in 24 states and that almost every other state medical society is in the process of developing plans, McCormick said:

"Up to now the states haven't had much to guide them. But from our studies of existing plans, we will make our first objective the development of a 'skeleton plan' for the guidance of communities now uncovered."

McCormick and other members of his council gave this version of their program:

1. All existing plans and those that may be developed in other areas will maintain local autonomy, but an attempt will be made to coördinate their activities on some common basis so that a subscriber to a plan in Ohio would be able to get medical care in Indiana if he got sick in the latter state.

"Blue Cross" Plan

"We hope to get things on such a basis," said Thomas A. Hendricks of Indianapolis, layman executive officer of the council, "that a man can carry a medical service card with him anywhere in the country and get the same service he would in his own home town."

2. Whereas some existing plans are indemnity systems (straight cash at time of sickness) and others are medical service plans (with the plan paying the doctor's bill), Dr. McCormick said the A.M.A. would "very likely" suggest the latter type in new areas.

"Medical care insurance," he said, "might be sold in all probability with hospital coverage programs—such as the Blue Cross.

"We now have enough actual experience from our studies of prepayment plans that we're certain that this type of medical and surgical coverage can be given at less than half the cost that any government plan would entail," McCormick added.—San Francisco *Chronicle*, December 6.

U. S. Health Plan Given Congress by President Truman

Washington, Nov. 19.—(INS.)—President Truman sent a special message to Congress today calling for compulsory national health insurance and legislation was promptly introduced in the Senate to carry it out.

The chief executive submitted a five-point program to Congress which would include Federal aid for construction of hospitals.

Four Per Cent Exacted

Mr. Truman recommended that health premiums be exacted on a basis of 4 per cent of earnings calculated on the first $3,600 of income.

"Premiums for present social insurance benefits are calculated on the first $3,000 a year," he explained. "It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount, such as $3,600."

The President declared "the poor have more sickness but they get less medical care."

Bill Introduced

Immediately after receipt of the President's message Senators Wagner (D., N. Y.) and Murray (D., Mont.) introduced a bill they said would carry out President Truman's recommendations.

The President's program called for:

1. Construction of hospitals, health centers and other facilities with Federal aid.

2. Expansion of public health, maternal and child health services with expansion of coöperative health programs between the federal and state governments with increased Federal funds.

3. Medical education and research under Federal grants.

4. Pre-payment of medical costs through a compulsory national health insurance system.

5. Protection against loss of wages from sickness and disability with disability insurance to protect America's families by guaranteeing some income when sick or permanently disabled.

No Socialization

The President emphasized that his program does not call for socialized medicine.

"I recommend solving the basic problem by distributing the costs to expansion of our existing compulsory social insurance system," he said. "This is not socialized medicine."

"Everyone should have ready access to all necessary medical, hospital and related services."

The President said that this system should cover hospital, nursing and laboratory services as well as dental care.

Choose Own Doctors

He emphasized that patients would remain free to choose their own doctors, physicians would remain free to accept or reject patients, hospitals would continue to manage their own services. voluntary organizations could participate in the insurance system, either to provide services and be paid therefore, or to assist in administration, depending on their functions.

President Truman declared that how much of the total health insurance fund should come from the insurance premiums and how much from general revenues is a matter for Congress to decide.

He said he believes "that all persons who work for a living and their dependents should be covered" under the plan and that this would include farmers, agricultural labor, domestic employees, government employees, and employees of non-profit institutions as well as wage and salary earners, those in business for themselves, and professional persons.

Millions Denied Care

The President pointed out that millions of Americans do not have a full opportunity to achieve or enjoy good health or have protection against the economic effects of sickness.

As a further point to back his recommendations, he pointed out that the Selective Service system "had to reject 5,000,000 young men or one-third of those examined," and that an additional 3,000,000 had to be discharged or rehabilitated.

He said that about 1,200 counties, or 40 per cent of the total in the country, with a population of 15,000,000, "have either no local hospital or none that meets even the minimum standards of national professional associations."

Needed For Cancer

The President said that a national program of medical research is especially necessary to conquer disease, especially cancer.

"Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year, and should receive special attention."—San Francisco *Call-Bulletin*, November 19.

State Aide Hails Health Plan

Possibility of increased Federal aid for coöperative state-Federal health program was greeted with enthusiasm here today by Dr. W. L. Halverson, State health officer.

"It is hoped that in any expansion there will be provision for local State autonomy in the planning and execution of the program with Federal support limited to setting of standards and approval of plans developed locally to meet local needs," Dr. Halverson said.

The greatest public health need in the United States, and California in particular, is for more full-time public health officers, Dr. Halverson said, explaining that only 29 of the 58 California counties employ such officials.

Present U. S. Grants

More than 1½ million dollars has been appropriated for health work in California for the fiscal year by the Federal Government. From the U. S. Public Health Service has come $1,009,721 for the venereal disease and tuberculosis program.

The Children's Bureau has supplied $523,932 to assist local health departments with their maternal and child health services. This includes pre-natal and well-child conferences, immunization programs, diagnostic and medical care for physically handicapped children—particularly those with rheumatic fever, and administration of the emergency maternal and infant care program for wives and children of servicemen in low-pay brackets.

Aid Cancer Work

President Truman's request for Federal aid for the advancement of research on the cause, prevention and cure of cancer brought cheer to the American Cancer Institute.

Mrs. Joseph Gould, president of the San Francisco chapter, said the institute, which has been carrying on an intensive education program, would be vitally interested in "any allotment" for cancer research, especially in California, where one out of seven persons die from the disease. The natural death rate attributable to cancer is one out of ten persons, she said.

Meanwhile, the compulsory health insurance program proposed for the nation by President Truman appeared similar to a program advocated for California by Governor Warren.

Bills containing the State program were defeated in the Legislature earlier this year, but Mr. Warren said last week he would continue to work for their enactment in the future.

The President's and Governor Warren's proposals were similar in requiring payment of an additional payroll tax, but allowing patients to choose their own physicians. Mr. Warren asked for a 3 per cent tax divided between employers and employees, while no specific rate was mentioned for the national program.—San Francisco *News*, November 19.

A.M.A. Senator Taft Sound Alarm on Health Plan; Stiff Fight Due

Washington, Nov. 20.—President Truman's far-reaching health insurance program today faced a hard fight in Congress.

Even backers of the three-billion-dollar-a-year proposal conceded that strong opposition lies ahead. Similar proposals introduced a year ago died in committee.

Despite Mr. Truman's repeated statement that his program did not mean "socialized medicine," the *Journal of the American Medical Association* charged editorially that the proposal would lead to "politically controlled medicine."

Senator Robert A. Taft (R., O.) also disputed Mr. Truman's denial that the program involved socialized medicine. President William Green of the A.F.L., however, telegraphed Mr. Truman congratulations on his "forward-looking" proposal which, Mr. Green said, "meets the most urgent human needs of our nation and merits universal support."

The President's plan would guarantee proper medical care for every American, financed through increasing Social Security taxes and, later, by taking monies from general tax collections.

One suggestion is to increase the Social Security tax

for the employer and the employee an additional 1½ per cent each on annual salaries up to $3600.

Senator James E. Murray (D., Mont.), one author of the bill, plans to start the month-long hearings within 10 days.—San Francisco *News*, November 20.

C.M.A. Favors Truman Health Program, But—

The California Medical Association today declared it favored President Truman's health insurance program, but asserted the method selected to achieve the objective would bring "regimentation of both patient and physician."

"The Association heartily approves of the President objective—'to assure prepayment of medical costs under a plan which would leave patients free to choose their own doctors'," said John Hunton, executive secretary.

"However, we just as vigorously disapprove of the method selected to achieve this objective—'a compulsory national health insurance system'."—San Francisco *News*, November 20.

Early Attention But Deferred Again

Washington, Nov. 20.—(AP.)—President Truman's request for a broad health and medical program received assurances today of early congressional attention but deferred action. Its points also met with both approval and disapproval of the American Medical Association.

Representative Priest (D., Tenn.), chairman of the House Interstate Health Subcommittee promised hearings soon, but he declined to say just when they would start or how long they might last.

Senator Wagner (D., N. Y.), who with Representative Dingell (D., Mich.), introduced a bill to carry out the President's recommendations, predicted Senate Labor Committee action within two months.

Otherwise, congressional reaction to the message read by a House clerk to about a score of members was indefinite. Most of the lawmakers told reporters they wanted to know more about it, particularly if it approached what some called *"socialized medicine."*—San Francisco *Chronicle*, November 21.

The President's Health Program

President Truman's message to Congress on a national health program presents the usual array of arguments used by the proponents of compulsory health insurance. There is the familiar insistence that it doesn't mean socialized medicine and the conventional gesture toward permitting voluntary coöperative organizations to participate "if they can contribute to the efficiency and economy of the system."

The presentation of broad generalities as to the need for more and better health and medical facilities is one thing; the translation of them into law short of socialization is another. California's recent experience with the various compulsory health insurance proposals exemplified this.

Good health, which does not necessarily mean perfect health, is man's most precious asset. Whether through private or public systems offering prepaid hospital and medical care or sickness insurance, the objective sought presumably is the same. The province of the state in the realm of public health has long been accepted. A basic question posed in compulsory health insurance is just how far the state should go in concerning itself with individual needs.

At first glance one would think that doctors who frequently find difficulty in getting their pay would welcome relief on this score. But many doctors nevertheless conscientiously oppose compulsory systems which they see as leading toward regimentation of their profession and the leveling off of the quality of service as the spur to individual incentive is dulled.

They may be wrong but thus far the record of American medicine when set against that of countries which have compulsory systems has not suffered by comparison.

There are so many different angles to the entire problem that generalities tend to oversimplify a highly complex problem. It is trite to say that no amount of money alone can buy good health. But it is true. The members of the medical profession themselves will be among the first to admit that they have not the answers to many of the problems involved in the mental and physical ailments which afflict mankind.

President Truman mentioned the Selective Service examination record but he did not analyze it from the standpoint of (1) either the lack of opportunity for proper care, or (2) whether medical care alone would have materially changed the picture. A recent report on 4,154,000 4-F's showed that 701,700 were disqualified for mental disease and another 582,100 for mental deficiency including those with low I.Q.'s and the illiterates. Those labeled "manifestly disqualified" included men without an arm, blind or who had other obvious defects. This left under the classification of "physical defects" 2,426,500.

Of this latter classification, the largest group comprised men rejected for musclar-skeletal causes. They numbered over 300,000, a third of whom were suffering from the results of injuries such as missing fingers, badly set bones and stiffening of the joints. Curvature of the spine, clubfeet, deformities of the toes, pigeon chests and the aftereffects of osteomyelitis also were included in this classification.

The second largest group were men suffering from syphilis. They numbered between 250,000 and 300,000. New drugs apparently have speeded up the cure of syphilis but doctors will tell you that the greatest difficulty in effecting cures in this (as in other diseases) is getting the patient's coöperation in sticking to the prescribed routine until cured.

Next to the syphilitic group came men with heart and circulatory ailments. Between 200,000 and 250,000 were rejected respectively for hernia, bad eyes and neurological ailments which covered a large number of epileptics. Bad ears caused the rejection of between 150,000 and 200,000 while tuberculosis was found in upward of 50,000. Under 50,000 each were groups rejected for overweight and underweight, bad feet, kidney and urinary ailments, varicose veins, bad teeth, bad skin, nose and throat trouble, gonorrhea and hemorrhoids.

The recital of the causes of these rejections at least tends to accentuate the complexity of the problems involved in a health program. Paradoxically many of these 4-F's will be active and alive after their more healthy brethren have passed away.

The Federal Government through public health measures, through aiding in the provision of needed hospitals and medical centers and in other broad ways can undoubtedly do much toward improving health standards. To the extent that it helps voluntary systems of prepaid hospital and medical care, it will be promoting a desirable movement which from all indications can be more fully exploited than it has been.

But Congress will be well advised to consider carefully the full implication and impact of a system of taxation and the disbursement of billions of dollars under compulsory health insurance.—Editorial in Los Angeles *Times*, November 21.

President Truman's "Must" Measures Gather Moss in Congress

Washington, Nov. 20.—President Truman's "must"

legislation is getting musty in congressional committees.

Although the President brought Congress back from a recess Sept. 15, his postwar reconversion program has made little progress.

Congress has passed a tax bill (not exactly to Administration specifications) and that's about all it has done legislatively. It did pass a bill to recapture excessive war appropriations. . . .

Most of the "must" legislation sought by President Truman was outlined in his message which he read when he called Congress into session after the summer recess.

From September 15 to October 26 the President sent 65 messages to Congress. Many of them dealt in detail with his legislative program. But after Thanksgiving Congressmen will be looking forward to Christmas holidays and it is likely to be well into 1946 before the Truman program takes shape—if then.—Daniel M. Kidney, in San Francisco *News,* November 20.

Health Insurance—President Truman's Proposals

We have long supported the efforts to establish a health insurance system in California. We believe a medical care program should be operated by the individual states and not by the Federal Government. We have a profound distrust of remote control by a vast Washington bureaucracy of a concern touching so intimately the lives of the citizens.

Our lack of confidence in the plan President Truman proposes is not made less by the language in which he describes it. On May 28 of this year we suggested to the California Legislature that it take careful note of Senator Wagner's then proposal of a vast Federal health insurance operation as a threat hanging over the State if it failed to install its own program. We then said that if there were no other defects immediately apparent in the Wagner scheme the language in which the New York Senator urged it would alone arouse deep suspicion.

We now find it is Wagner's sleeping plan which is revived to be brought before Congress at this moment and that in urging it President Truman has only echoed what Wagner said last spring.

The President repeats Wagner in asserting that this plan is not "socialized medicine." "Socialized medicine," he said, "means that all the doctors work for the Government." That is only Truman's, or rather, Wagner's definition. There is more than one way of tying a knot. Wagner said it would not mean "regimentation." Any compulsory rule laid on the citizens is regimentation. We could have regimentation in a State system, too; we recognize that, but it is the unfrankness of these declarations that rouse us here. To us these assurances are nothing more than attempts to soothe persons who do not like the terms "regimentation" and "socialized medicine." They should not fool anyone who can put two and two together.

Similarly unfrank seems the President's assertion that the system must be "highly decentralized in admiinstration" though the fund "should be built up nationally." These two elements are completely incompatible. Whoever holds the purse runs the show and from the place where the money is held. Nothing run by Washington is ever decentralized. OPA is a good example; it is supposed to be decentralized with district and local administrators, but anyone who has had dealings with it knows every new question has to be referred to Washington. In other words, you can't decentralize centralization.

We agree that a health insurance program should be decentralized. In our opinion the best and only chance of a degree of decentralization lies in state-run health insurance systems. Who wants to wait on Washington to decide whether his particular kind of case is in the rule book?

We assume it is only to catch the doctors that the President spreads the molasses of "more money for all of them." We are unable to calculate how this could be on the basis of the President's statement that the requisite 4 per cent tax to raise the fund is only about what Americans now spend for sickness care.

We do not want another national bureaucracy to create another huge pressure group in Government.—Editorial in San Francisco *Chronicle,* November 21.

Assembly Interim Committee on Sickness Insurance

Representatives of the San Francisco Municipal Health and Hospitalization Insurance System, the Blue Cross and the California Physicians' Service were invited to present their views on health insurance before a session of the Assembly Interim committee on health care, held in San Francisco, on November 9 and 10.

Assemblyman Ernest Geddes, chairman of the committee, announced scheduling of the San Francisco meeting.

The committee was created by the Assembly as a result of the movement started by Governor Warren for establishment of a system of compulsory health insurance in California.

Interim Committee must submit a report before July, 1946.

The 1945 Wagner-Murray-Dingell Bill

A Bold Plan: Its Provisions Are Controversial—Its Implications Are Grave

Importance.—The importance of the 1945 Wagner-Murray-Dingell Bill lies not so much in the likelihood of adoption in its present form as in the fact that it demonstrates the determination of its advocates to secure action. This in spite of the lack of consideration accorded the original measure.

Compared to the Original Measure, introduced in the previous Congress but never considered, the new measure differs mainly by reason of the effort made, through various devices, to appease certain opponents and to draw in greater and more enthusiastic support.

Most important of these devices is the *reduction of the "contribution" rates* proposed as compared to those proposed originally. Labor support had been tempered by expressions of doubt concerning the 6 per cent payroll deductions first advocated. It is to be presumed that labor will find the 4 per cent rate now proposed much more acceptable. Washington reporters, however, have made allusions to the possibility that Chairman Altmeyer, of the Society Security Board, suspects that the bill is financially unsound. Apparently the reduction in contribution rates is wholly accounted for by adoption of a pay-as-you-go principle with respect to Old-Age and Survivors' Insurance financing.

Congress now has before it the Hill-Burton bill providing for Federal aid in *hospital construction and maintenance.* In view of the support accorded this measure, the inclusion of a more or less similar proposal, outlined in great detail, in the new Wagner bill has been widely commented upon. Most commentators agree that Senator Wagner hopes, in this way, to draw additional support to his measure.

The new Wagner bill includes an attempt to decentralize the administrative setup proposed to carry out its medical care provisions by providing for localized control. In introducing the measure to the Senate, Senator Wagner called attention to this as evidence of the lack

of any purpose or desire to *"socialize" medicine.* Editorial comment in leading medical journals does not indicate any hope of success for this appeasement effort.

Cost.—Neither the sponsors nor any official agency have published estimates of the cost of the proposed program of compulsory social security. This omission has been noted by numerous editorial writers through the country.

Private sources—such as Research Council for Economic Security—have estimated the ultimate cost at $15 billion upwards, annually. On the basis of an immediate cost of $10 billion a year (much of it for health insurance) and an ultimate cost of $15 billion a year, the program proposed would absorb 8 to 12 per cent of a national income of $120 billion annually. This would mean from 12 to 17 per cent of payroll.

Foreign experience indicates that no sound economy can bear such a cost and still maintain the momentum of private incentive and enterprise.

Costs.—The above estimates may be too conservative. For example, the spring (1945) issue of Quarterly Journal of Economics, contained a detailed, actuarial study of "Estimated Cost of Old-Age and Survivors' Insurance," by Professor I. J. Sollenberger, University of Oklahoma. So far as is known, it is the first attempt to establish the ultimate cost of the system as it might be expanded by adoption of the Wagner bill. The study indicates that this part of the program alone might involve an ultimate cost of not far from 10 per cent of payrolls, and thus, in itself, create too great a burden upon private enterprise, without considering the cost of health insurance, unemployment compensation, etc.

Consequences.—Too costly a program may have grave and unexpected results. High taxes handicap enterprise, discourage expansion, scare off investments and undermine job stability. As private enterprise retreats, government activity is likely to expand in fields of production, distribution, finance, transportation, public utilities and general economic planning.

The proposed program attempts to redistribute income and thus support consumer buying. But if, by discouraging enterprise, it restricts production, will there be enough goods to distribute? In other words, will standards of living in this country tend to decline?

Snowball Tendencies.—The sanguine attitude of advocates of expansion of compulsory social security toward costs is not justified by experience either at home or abroad. In foreign countries, where the experience is much longer, it has never been possible for politicians to resist demands for continuous expansion and costs have mounted steadily through the years. Domestic experience while much shorter, follows the same pattern. As one author puts it, one is reminded of a snowball rolling down hill and gathering both size and velocity on its journey.

Enterprise Ignored.—The advocates of the program placidly ignore the accomplishments of and the opportunities offered by private enterprise. Despite the outstanding accomplishments of private enterprise in recent years, they do not admit the possibility that enterprise is any longer dynamic.

The extensive and rapidly increasing structure of protection built up by voluntary insurance institutions and through other types of thrift programs is likewise ignored. Indeed, much of the coverage proposed by the Wagner bill would only replace existing protection.—*Insurance Economics Society of America Bulletin.*

President Truman's Health Plan Criticized

Kansas City, Nov. 26.—(AP.)—Dr. Harold T. Low, Pueblo, Colo., today described President Truman's proposal for medical care as "an utopian dream and if tried will be a failure like the prohibition law."

Dr. Low is president of the Association of American Physicians and Surgeons.—San Francisco *Chronicle,* November 27.

Public Health Plans Backed

State Group Favors Medical Care Insurance Program

Sacramento, Nov. 5.—(AP.)—The State Reconstruction and Reëmployment Commission voted, 5 to 4, today to approve the recommendation of a citizens' advisory committee urging early enactment of a State-wide program of public health and medical care insurance.

Voting for health insurance were Percy Keckendorf, State director of professional and vocational standards; Dr. Robert Gordon Sproul, president of the University of California; Paul Scharrenberg, director of industrial relations; William T. Sweigert, executive secretary to Governor Warren. (Query. Was the 5th vote recorded in the majority list of 5, that of the late Walter F. Dexter, California Superintendent of Public Instruction, whom death antedated the meeting referred to by several weeks?)

Voting in favor of taking no action at this time on the health insurance recommendation were:

James S. Dean, State finance director; Charles H. Purcell, director of public works; Warren Hannum, director of natural resources, and A. A. Brock, director of agriculture.—San Francisco *Examiner,* November 6.

Doctors Rap State Group's Health Stand

Through Dr. John Cline, chairman of its executive committee, the California Medical Association (C.M.A.) on November 6, took public exception to the action of the State reconstruction and reëmployment commission in urging creation of a compulsory health insurance system.

Declaring that "the commission seems more interested in political reconversion than in further industrial reconversion and reëmployment," Doctor Cline added:

Hints Politics

"When there are so many pressing reconversion problems which come within the commission's scope, and which are far from solved, it is unfortunate that the commission should go beyond the purview of the act which created it to dabble in as controversial a political issue as State medicine."

Health insurance became a political issue last January, when Governor Earl Warren asked the Legislature to set up a State-operated system. Several bills, including two sponsored directly by the Administration, died in unfriendly legislative committees and no health insurance program reached the floor of either house for a vote.

The reconstruction and reëmployment commission on Monday voted 5 to 4 to approve the recommendation of a citizens' advisory committee urging early action to establish health insurance. Doctor Cline, on behalf of C.M.A., branded this act as "presumptuous," and asserted that the commission has permitted itself to become "a propaganda agency and a pleader for special causes."

Meanwhile, two special interim committees of the legislature are making a study of the entire question of voluntary versus compulsory health insurance and prepaid medical care.—San Francisco *Examiner,* November 7.

Governor Warren Still Advocates Health Insurance, Desires Program

Governor Earl Warren has not changed his opinion in the slightest about prepaid state health insurance, despite his defeat in advocating it at the 1945 legislative session, and he is hopeful the Senate interim investigating committee will bring the importance of this issue even more forcefully to public attention.

This was made abundantly clear in a brief statement by Warren just before he left Sacramento last night for a series of governmental conferences in the Middle West.

The special senate committee on payment of medical and hospital care, charged with making a complete survey of the public health insurance question, will meet in the capitol tomorrow.

Glad Committee Active

"I am happy that the senate committee is becoming active," commented Governor Warren, "and I trust it will make a thorough study of the situation and advise both the Legislature and the public of the necessity for making a direct attack on this major health problem of our people.

"The health of the people is the most fundamental problem in American life today. Any fair and impartial study of the problem by our Legislature should bring us closer to a solution."

Supporters of the two prepaid health insurance measures which were presented unsuccessfully at the regular legislative session—one by Republican Governor Warren, the other by the Congress of Industrial Organizations—are inclined to figure a majority of the senate committee as possibly favorable to such legislation. The Warren and CIO bills were stymied in the assembly and did not come to a senate vote.

Salsman Heads Group

The senate investigating committee is headed by Senator Byrl R. Salsman of Santa Clara County, author of a Warren proposal similar to that defeated in the lower house. Serving with him is Senator John F. Shelley of San Francisco, accounted an advocate of health insurance. The other three committeemen are Senators Chris N. Jespersen, San Luis Obispo County; Louis G. Sutton, Colusa County, and Arthur H. Breed, Jr., Alameda County.

The assembly also has a health care investigating committee (of seven members) on which Speaker Charles W. Lyon, opposed to the Warren proposal, has appointed a majority who voted to keep both the bills of the administration and the CIO bottled up in committee last Spring.

Senator Salsman announced a part of tomorrow's session of the upper house study group will be devoted to considering qualifications of persons suggested for the post of investigation research expert. He said the committee intends to employ "an impartial and unbiased expert to survey the problem of medical care in California and advise on questions of need and cost."

Program Still Alive

Developments of the last fortnight show plainly enough that the prepaid health insurance program and the controversies which grew out of its presentation to the last Legislature are far from dead.

The State reconstruction and reëmployment commission, for instance, voted at its last meeting to approve recommendations by a citizen advisory committee on social and industrial welfare in favor of early enactment of a health insurance law.

Immediately the California Medical Association high command swung into action with a vigorous denunciation of the RRC.

The recommendation which the RRC endorsed simply read as follows:

"That the State Reconstruction and Reëmployment Commission give every possible assistance to the interim committee of senate and assembly in order that a sound program of health insurance and medical care may be enacted at the earliest possible date."

Politics Charged

This drew a quick charge from Dr. John Cline, chairman of the executive committee of the California Medical Association, that the RRC in apparently "more interested in political reconversion than in furthering industrial reconversion and reëmployment."

Of course, six of the nine RRC members who voted to endorse health insurance are members of Governor Warren's cabinet, so it was not exactly surprising that this agency should agree with Warren's advocacy of extending social security in the field of health and medical care.

Dr. Cline, however, had this to say:

"When there are so many pressing reconversion problems which come within the commission's scope, and which are far from being solved, it is unfortunate that the commission should go beyond the purview of the act which created it to dabble in as controversial a political issue as State medicine."

Merry Go Round Begins

Then the political merry go round started off full tear on health insurance. The assembly investigating committee called a meeting. Then the senate committee called one.

Next came predictions from a source decidedly friendly to the California Medical Association that a drive to abolish the reconstruction and reëmployment commission will be made by "indignant lawmakers" when Governor Warren calls his expected special legislative session.

This forecast was circulated by Clem Whitaker, the San Francisco publicity agent and campaign manager who opposed Warren's health insurance bill in the Legislature. He reported people are sore at the RRC, among other things, because it has "gone beyond the scope of activities laid down for it by the legislature and has sought to become a policy making board and to influence legislation . . . giving a favorable recommendation to such red hot legislative proposals as compulsory health insurance . . ."

Allied With C.M.A.

Capitol quarters well disposed toward the RRC pointed out Whitaker was engaged in the fight of the C.M.A. and affiliated forces to defeat compulsory health insurance this last Spring.

The Warrenites emphasized that Whitaker now is one of the chief boosters of Earl Lee Kelly as a potential Republican candidate for Governor against Warren.

And Kelly, in turn, they added, is damning Warren for proposing health insurance in the first place.—Herbert L. Phillips in Sacramento *Bee*, November 14.

U. S. Health Aid Planned

Washington, Oct. 19.—A revamped bill for Federal aid to hospital and health center construction is ready today for approval by the Senate education and labor committee.

It will provide for Federal grants amounting to 75 million dollars a year for five years. In addition, it appropriates five million dollars for a survey of the nation's hospital and health center needs.

Originally introduced by Senators Hill (D., Ala.), and Burton (R., O.), it was rewritten in a subcommittee of which Senator Hill was chairman.

Under the revised measure a formula is provided for distribution of the funds on a population and per capita wealth basis. It will give 15 of the poorest states, mostly in the South, 47.8 per cent of the funds; 16 middle bracket states 18 per cent and 18 richest states, 31 per cent. Territories would get 3.2 per cent.

The original plan for matching funds for public and non-profit hospitals on a 50-50 basis was abandoned. Instead the Federal contribution will range from 33 per cent for the richest states to 75 per cent for the poorest.

No state can obtain a grant of less than $10,000 a year, but it may borrow Federal funds for matching purposes.—San Francisco *News*, October 19.

Doctors Are Against "Political Medicine"

Los Angeles (UP.)—Government sponsored health programs were denounced today by Dr. L. A. Alesen of the California Medical Association as "political medicine."

Alesen, addressing delegates to the California Farm Bureau Federation regional convention, attacked both large and small medical service plans and described the American system of individual medical attention as the best in the world.

Dr. Clifford H. Loos told delegates the health of Californians must not be endangered by "chain store" medical methods.

"I firmly believe in group medicine, but it must be in localities, not on a national or even state scale," he said.—Merced *Sun-Star*, October 26.

Warren Firm On Health Plan

Sacramento, Nov. 14.—Governor Warren indicated today he has not given up hope of enactment of a State health insurance program in California.

Before leaving on an Eastern trip, the Governor was asked to comment on the opening of hearings on November 15, on health insurance plans by a Senate interim committee. He said he had not changed his mind since advocating an insurance bill at the Legislative session earlier this year.

Senator Byrl Salsman (R., Palo Alto), chairman, had asked Governor Warren to appear before the committee, but the Governor said he was prevented by earlier plans to attend a conference of Governors' meetings in Chicago and Cheyenne, Wyo.—San Francisco *News*, November 14.

Francis Thompson (1859-1907).—Thompson called his body "a Pandora's box, containing all the ills that afflicted humanity." Possibly, his "long feverish illness," at the age of 20, was an early sign of the tuberculosis from which he died. At this time also, he became acquainted with opium as a result of his mother's gift of "Confessions of an Opium Eater." Disease, opium and poverty reduced him to a life on the London streets, fetching cabs and selling matches. The moral tone of his literary work remained high.—Warner's *Calendar of Medical History*.

For they lived long enough, that have lived well enough.
—Thomas Wilson, *Arte of Rhetorique*, 83. (1560).

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Typhus Fever—Los Angeles Report

George M. Uhl, M.D., Health Officer of City of Los Angeles, recently reported:

There have been 19 cases of typhus fever in the city of Los Angeles during the first 10 months of 1945, in contrast to 8 during the same period of 1944, and an average of 10 cases annually for the past five years. Ten of the 19 cases were reported during the months of September and October. Seven persons were bitten by rats in October.

There are two types of typhus fever: 1. *Epidemic,* which is transmitted from one human being to another by the bite of the body louse (clothes louse). This type is common in Europe and has a high mortality; and 2. *Endemic,* which is transmitted to human beings from the rat by the bite of the rat flea (xenopsylla cheopis). This type occurs in Southern California and has a low mortality.

In order to control the endemic type it is necessary to control rats. However, the Los Angeles City Health Department does not operate a rat exterminating service except for public areas. The Rodent Control Division of the Health Department keeps an index of the rat population, examines rats for the presence of diseases transmissible to human beings, and coöperates with the U. S. Public Health Service and the State Health Department in administering and enforcing laws which require property owners to maintain their premises in a rat-free condition. It would be impossible for the personnel of this division to make any substantial dent in the rat population of the city merely by extermination.

The Los Angeles City ordinance requires owners of buildings to:

1. Ratproof or rat-stop all buildings by screening foundation vents, closing openings, etc.;
2. Store in ratproof containers all material (food, animal feed, garbage, etc.) that may afford food for rats;
3. Destroy rat harbors by eliminating accumulations of rubbish, junk, etc.;
4. Diligently exterminate rats.

All of these methods of rat control must be carried out by all property owners to significantly control the rat population. The Los Angeles City Health Department calls on all home and building owners to coöperate in eliminating this menace.

Hooper Foundation of U.C. Studies Encephalitis

The reservoir of infection of encephalitis, which exists in many west coast areas, has been found to be birds, both wild and domestic, according to Dr. W. H. Hammon, associate professor of epidemiology, and Dr. W. C. Reeves, research associate, at the Hooper Foundation for Medical Research on the San Francisco campus of the University of California. The infection by the virus causes no disease in the birds but produces a serious illness in both horses and man.

Transmission of the virus is by means of the bite of a mosquito which first has fed on the infected birds, Dr. Hammon says. Thousands of other biting pests, including ticks, mites, fleas, lice, flies, kissing bugs, and bed bugs, have been collected by staff members of the Foundation and tested as carriers, but only mosquitoes have been found to be infected. A study of the feeding habits of the principal mosquito vectors shows that they prefer to feed on birds, followed in order of preference by cows, horses, and man. Only 2 per cent or less feed on man, the research shows.

Horse encephalitis is common in most west coast areas, but can be controlled by vaccination. In man the disease has caused sharp explosive epidemics but usually is confined to endemic areas in the hot valleys. The incidence in any area rarely exceeds about one in a thousand of the population, so large-scale vaccination of humans is not recommended. Cases occur in rural areas, small towns, and in the suburb areas of large cities where chickens are kept in back yards. Mosquito control in these areas is recommended as the first line of defense.

Kenny Poliomyelitis Drive

Half of Funds Stay in State

One-half of the funds raised in each state during the Sister Elizabeth Kenny appeal starting November 22 will remain in that state to aid the local fight against infantile paralysis, it was announced recently.

Objectives of the campaign are to build Kenny hospital wings and clinics, to provide Kenny treatment for infantile paralysis patients, and to provide scholarships for graduate nurses to become Kenny technicians.

"If we are to win the battle against infantile paralysis there must be funds for research and funds for the treatment of those who fall victim to its ravages," E. G. Hubbard, Northern California campaign chairman, said.

"It is our hope that the Sister Kenny method of treating infantile paralysis can be brought into every community, that a Kenny trained technician can be assigned to hospitals in every hamlet so that when infantile paralysis strikes it will find opposition."

Fourteen Signs of Illness in Children

A recent bulletin of the Health Advisory Council of the Chamber of Commerce of the United States, Washington, reminded mothers of 14 signs of illness in children to which particular attention should be paid.

The 14 signs, which may indicate any one of a number of serious illnesses requiring the immediate attention of a doctor, have been listed by the Children's Bureau of the U. S. Department of Labor. They are:

"Fever.—Flushed cheeks and hot dry skin.

"Irritability.—Fussing and whining by a child who usually plays and is happy.

"Drowsiness.—Wanting to sleep more than usual, especially at a time when he usually plays.

"Loss of appetite.—Refusal of foods by a child who usually eats well.

"Vomiting.—May be after eating or taking liquid or may not. Notice whether vomiting is mild or forceful (projectile).

"Diarrhea.—A sudden increase in the number of stools, especially if they are loose and watery. This may be an early sign of any infection or of a disease of the bowels. If pus, blood, or a large amount of mucus is in the stools, the doctor should be called.

"Runny nose.—A running nose in a child may be the beginning of a cold or of some other communicable disease, such as measles, influenza, or whooping cough.

"Cough.—A cough in a child is more likely to be a sign of illness than in a grown person.

"Sore throat.—May be associated with a cold or may be the beginning of another communicable disease, such as diphtheria or scarlet fever.

"Hoarseness.—A huskiness in the voice, if accompanied by fever, may be the first sign of diphtheria. A doctor should be called at once.

"Pain.—A child who complains of persistent pain in any part of the body should be seen by a doctor. Earache, severe headache, or pains in the stomach, abdomen, chest, or joints may indicate serious disease, infection, or injury.

"Convulsions.—Convulsions, spasms, 'fits,' or twitching of the face or arms or legs may be an early sign of some serious disease in the child.

"Stiffness of the neck or back—May be associated with disease or irritation of the nervous system.

"Rash.—A breaking out on the child's skin."

A child with any of these 14 signs of illness should be put to bed, and if his temperature is over 101 degrees, a doctor should be called.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

American Medical Association. Next annual session will be held in San Francisco, Monday-Friday, July 1-5, 1946.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, CALIFORNIA AND WESTERN MEDICINE, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

Medical Broadcasts*

The Los Angeles County Medical Association:

In December, KFAC will present broadcasts on Saturdays at 10:15 a.m.: December 1, 8, 15, 22 and 29.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

Pharmacological Items of Potential Interest to Clinicians*:

1. *Symposia:* Excellent one on cardiac output by A. F. Cournand, W. F. Hamilton, I. Starr, J. L. Nickerson, J. McMichael and D. W. Richards (*Fed. Proc.*, 4:183-220, 1945). Then go on to W. F. Hamilton & Co.'s neat studies on propagation velocity of arterial pulse wave, cardiac ejection curves, and ballistocardiographic forces (*Am. J. Physiol.*, 144:521-570, 1945). Note papers on intervertebral disc and lumbago by E. J. Crisp, B. H. Burns, R. H. Young and J. Cyriax (*Lancet*, 249:422-429, October 6, 1945). Important series on physics in medicine by W. V. Mayneord, H. Hurst, G. E. Donovan, D. S. Evans, K. Mendelssohn and A. H. S. Holbourn (*Brit. Med. Bull.*, 3:129-151, 1945), including interesting historical notes. Note potential competition from R. Geigy & Co. on recent researches on malaria in Switzerland (*Acta Tropica*, 2:1-159, 1945).

2. *Ethics:* P. Romanell takes "Ethicogenesis" for a technical hayride (*Sci. Month.*, 61:293, 1945; for other cracks see p. 329). O. L. Reiser looks to the *Promise of Scientific Humanism* (Creative Age Press, N. Y., 382 pp., $4), and proposes an institute of scientific humanism (*Philos. Sci.*, 12:45, 1945). Meanwhile G. Sarton publishes *Isis*, and too few help him. W. A. R. Leys writes on *Ethics and Social Policy* (Prentice-Hall, N. Y., 522 pp., $3.50). A. Edel discusses key concepts in ethical theory (*Philos.* Rev., 12:260, 1945). A. Robertson offers *Morals in World History* (C. A. Watts, London, 1945, 126 pp., $2.50). C. L. Stevenson joins *Ethics and Language* (Yale, New Haven, 1945, 350 pp., $6). A. M. Schwitalla S. J. undertakes to edit *The Linacre Quarterly*, a journal of the philosophy and ethics of medical practice from the orthodox standpoint. D. M. Emmet describes *Nature of Metaphysical Thinking* (MacMillan, 1945, 238 pp., $2.50), which contains statements, if you're interested, about the real which transcends experience! Vale to B. Malinowski who closes career with *Dynamics of Culture Change* (Yale, New Haven, 1945), and *A Scientific Theory of Culture* (University No. Carolina, Chapel Hill, 1945, 228 pp., $4). A. G. Ramsperger notes misplaced modesty of scientists (*Antioch Review*, Winter, 1945, p. 581). A. Dresden's Mathematics as an Intercultural Bridge remains unpublished from 6th conference on Science, Philosophy and Religion, and it's pertinent. Lots of physicists seem willing to accept responsibilities of implications of current scientific work; why not a series of seminars, conferences and congresses with biologists, physicians, sociologists, philosophers and policy leaders? Note A. R. Zhebrak's comment (*Science*, 102:357, October 5, 1945). British scientists propose international science coöperative service (*Nature*, 156:401, October 6, 1945).

3. *Antibiotics:* M. I. Smith and W. T. McClosky find streptomycin has chemotherapeutic index ten times that of promin in experimental TB (*Pub. Health Rep.*, 60:1129, September 28, 1945). H. A. Zintel & Co. report streptomycin blood levels well maintained with slow urinary excretion, low toxicity, no side actions, wide tissue distribution, poor oral absorption (*Am. J. Med. Sci.*,

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In CALIFORNIA AND WESTERN MEDICINE, some rosters appear in every second or third issue.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacological Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

210:421, 1945). B. A. Johnson & Co. obtain "bacitracin" from B. subtilis, a water soluble, non-toxic, heat stable, effective agent vs. hemolytic stretococci and staphlococci (*Science*, 102:376, October 12, 1945).

4. *News:* G. R. Herrmann and P. A. Rockwell report on reversable and irreversable liver disease in reference to choline (*Texas St. J. Med.*, 41:288, 1945). D. E. Clark & Co. conclude that lipotropic effect of lipocaic is due to some factor other than choline, methionine or protein action (*Am. J. Physiol.*, 144:620, 1945). B. A. Houssay and J. Sara observe that thyroid enhances toxic and diabetogenic action of alloxan (*Rev. Soc. Argent. Biol.*, 21:81, 1945). E. de Robertis and W. W. Nowinski find proteolytic effect of pathological thyroid greater than normal (*Ibid.*, p. 120). A. Van Harreveld notes reinnervation of denervated fibers by adjacent functioning motor groups (*Am. J. Physiol.*, 144:477, 1945). A. E. Ritchie reviews physiology of peripheral nerve injury (*Edin. Med. Surg. J.*, 52:289, 1945). N. W. Shock and W. H. Sebrell observe increased work output (from frog muscle) after thiamine pyrophosphate (*Proc. Soc. Exp. Biol. Med.*, 59:212, 1945). R. Gubner and J. DiPalma say that glycine increases peripheral blood flow (*Ibid.*, 170). E. Gellhorn reports recovery of inhibited conditioned reflexes after shock therapy (*Ibid.*, 155). H. L. Hamilton surveys biochemorphology of p-aminobenzoic acid inhibition of rickettsial growth (*Ibid.*, 220). J. B. de C. M. Saunders and W. Haymaker compare sulfa drug toxicity on chick brain cultures (*Ibid.*, 306). Enjoyable is C. D. O'Malley and J. B. de C. M. Saunders note on St. Apollonia (*J. Am. Coll. Dent.*, 10:101, 1945). H. L. Segal propose anion exchange resin (polyamine formaldehyde) to control gastro-enteric pH (*GastroEnt.*, 4:484, 1945). W. H. Lewis and A. G. Richards find DDT nontoxic to cells in culture (*Science*, 102, 330, September 28, 1945).

Premarital and Prenatal Laws in Effect Five Years.—Five years of operation of the California laws requiring premarital and prenatal tests for syphilis were completed in September. Total number of tests performed under both laws had nearly reached the two million mark by the end of September, 1945.

With the migration into the State during the war of a large number of people from states which have syphilis rates higher than the rate in California, the number of positive and doubtful premarital and prenatal tests has risen.

During the first nine months of 1945, 2.2 per cent of premarital tests and 2.3 per cent of prenatal tests were reported as positive or doubtful. The percentage of positive and doubtful tests during the five-year period is: premarital, 1.9 per cent; prenatal, 1.7 per cent.

From September, 1939, through August, 1945, 963,058 premarital tests were reported of which 724,408 were performed in private laboratories. During the same period, 942,143 prenatal tests were reported, of which 453,318 were performed in private laboratories.

Plague Demonstrated in Wild Rodents in Seven California Counties.—Plague has been demonstrated in wild rodents and their ectoparasites collected in seven counties by survey crews of the Bureau of Sanitary Inspections during the summer months.

The counties are: Alpine, Kern, Merced, Placer, San Benito, San Bernardino and Santa Clara. *C. beldingi*, *C. beecheyi* and golden mantled squirrels and their fleas, ticks and lice are involved in the findings.

During the first nine months of 1945 survey crews collected and examined 30,298 wild rodents. Over 310,000 fleas, 1,700 ticks and 6,800 lice were collected and sent to the State Laboratory for examination. All rodents showing suspicious lesions also were examined in the laboratory.

Rat trapping operations were conducted in 67 cities and towns during the first nine months of the year in which 20,764 rats were collected and examined and 12,000 fleas were sent to the laboratory for examination. Up to October 1st, plague had not been demonstrated in any rats or their fleas.

National Foundation for Infantile Paralysis Appropriations.—In the year ending last May 31, the National Foundation allotted the unprecedented sum of $4,157,814.15 for research, education and epidemic relief—exceeding authorizations for any previous year by more than $2,000,000.

During the 12 months covered by the 1945 Annual Report, appropriations were as follows:

For public health groups, hospitals and universities, to train competent personnel and broaden public understanding of the polio problem, $2,108,674,52;

For emergency epidemic aid, $1,461,680.55;

For scientific research and investigation, $304,444.36;

To universities, hospitals and the U. S. Public Health Service for the study of more precise methods of reporting clinical cases, $406,427.09.

These appropriations do not include disbursements authorized in previous years for long range programs, some for as long as five years. During the preiod covered by this report, $245,439.02 was distributed on such long-term grants.

Neuropathologist for Langley Porter Clinic.—Dr. Nathan Malamud has been appointed as neuropathologist at Langley Porter Clinic and associate clinical professor of psychiatry in the Medical School on the San Francisco campus of the University of California. In announcing the new staff member, Dr. Karl M. Bowman, director of the Clinic, says that while an excellent neuropathological laboratory was constructed when the clinic was built, this is the first appointment of a full time neuropathologist, and will further the plans to attack the problem of mental disease from every possible angle.

Neuropathological material will be received from all the State hospitals. Thus Langley Porter Clinic will not only be coördinated with the Medical School of the University but will be the focus for these studies for the State hospital system, thus enabling the Clinic to enlarge its services to the state.

American Association for the Study of Goiter.—The American Association for the Study of Goiter again offers the Van Meter Prize Award of three hundred dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Chicago, Illinois, in April or May, 1946, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia not later than February 20, 1946. The Committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

Architect Speaks to Public Health Group.—Planning for Public Health was the topic of a discussion

before the annual meeting of the Northern California Public Health Association, by Michael Goodman, associate professor of architecture on the Berkeley campus of the University of California. Speaking at the evening session November 16, his talk was based on a collaborative investigation conducted by the department of architecture and the school of public health under the direction of Professor Goodman and Mrs. S. P. Lucia, associate professor of biometry. Drawings made by students of architecture were used to illustrate the lecture.

Joint speaker of the evening was Colonel Alexander Heron of the State Reconstruction and Reëmployment Committee, who told about the State program of postwar building and public projects.

Christian Science Practitioner Signatures to Sick Leave Forms.—The *San Francisco Municipal Review*, November 16, states: "At the request of Commissioner Allan E. Charles the annual sick leave ordinance is being amended to permit the signature of a Christian Science practitioner on sick leave forms. Currently the Civil Service Commission recognizes only the signature of a Doctor of Medicine on the sick leave forms."

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

President Truman's New Health Plan Before A.M.A.

Acting Surgeon General of V. A. Protests Government Medical Control

Chicago, Dec. 4.—(UP.)—American Medical Association delegates, representing more than 125,000 physicians, met today to answer Preident Truman's proposal of a national health program.

More than 40 resolutions, many of them voicing the medical profession's opposition to the President's request for universal sickness insurance and health care were scheduled for consideration.

Maj. Gen. Paul R. Hawley, acting surgeon general, of Veterans' Administration, told A.M.A. delegates last night that a "free and uncontrolled medicine will solve its own problems and doesn't need the Government to tell it how."

He made no direct reference to Mr. Truman's proposal but emphasized that he did not approve of Government interference in the medical field.

"No Federal Control"

"Although I've been in Government service for thirty years, I don't want to see the Government control medicine throughout the country," he said.

General Hawley, medical director of the Veterans' Administration, said the V.A. had done an unprecedented job in treating thousands of veterans with an inadequate number of doctors, but he added that private physicians would have to participate to make the veterans program successful.

General Hawley disclosed that a program would enable doctors to offer their services on a part-time basis in veterans' hospitals, receiving standard fees from the Veterans' Administration.

The incoming president, Dr. Roger I. Lee, Boston, who was inaugurated last night, stressed the need for "constant and continuing" study to determine what constitutes "adequate" medical care.

He said that "while there have been many clarion shouts that medical care in the United States is inadequate," these claims too often failed to include the individual's attitude toward treatment by physicians.—San Francisco *News*, December 4.

A.M.A. Unanimously Opposes Truman's New Health Program*

Chicago, Dec. 4.—(INS.)—The American Medical Association today unanimously disapproved President Truman's plan for Federal tax supported health insurance.

The A.M.A. House of Delegates indorsed a statement describing the Truman plan as "socialized medicine" that would put the physician and his patient under political control and make doctors "clock watchers and slaves of a system."

The delegates adopted that part of the President's plan covered by the Hill-Burton bill, which provides for Federal aid for the construction of hospitals and health centers.

Also adopted was the point asking for the development of a national research foundation, as introduced in the Magnusen bill. The delegates, in approving that point, specified that the foundation should be headed by a board of scientists, rather than a presidentially appointed individual, as suggested in the Kilgore bill.

Points referred back to committee were on compensation for loss of earnings due to sickness, and the extension of maternal and child health services, which the Wagner-Murray-Dingell bill would make effective by increased grants through the children's bureau to various states.

* * *

A resolution of the California delegation that no employee of the A.M.A. be permitted to have any other source of income was defeated, and two other resolutions of that delegation were referred back to committee.—San Francisco *Examiner*, December 5.

Hotel Del Monte Reported Sold As Naval Academy

Washington, Nov. 13.—California's fashionable 1,500 room Hotel Del Monte near Monterey, one of the West's most famous luxury hotels, has been secretly taken under option by the Navy Department, according to information today in the hands of Representative Gordon L. McDonough.

The California Congressman said he has been informed Del Monte will be used as the site of a naval academy postgraduate school. . . .—San Francisco *Call-Bulletin*, November 13.

Science Finds New Elements

Chicago, Nov. 16.—(INS.)—Dr. Glenn T. Seaborg, University of California chemist, today announced the discovery of two new elements in addition to plutonium, used in atomic bomb manufacture.

The two elements, as yet unnamed, are numbers 95 and 96 on the periodic table of known elements. They possess properties that are of the "rare-earth-like" series which starts with element 89, actinium, Dr. Seaborg said.

The new elements were found as a result of bombarding uranium 238 and plutonium 239 with high energy helium elements of 40 million electron volts.

Dr. Seaborg was co-discoverer of the new elements and of neptunium 237, a more stable twin of neptunium, element 93. He also was co-discovered of plutonium, in 1940.

He said that plutonium, which he isolated in a University of Chicago laboratory, has been found to exist in minute amounts in a natural state.—San Francisco *Examiner*, November 17.

Atomic Bombs at Low Cost Predicted by Dr. Oppenheimer

Philadelphia, Nov. 16.—(AP.)—Atomic bombs cheap enough so that tens of thousands of them may be dropped in the next war were predicted today by Dr. J. Robert Oppenheimer, the former University of California scientist who headed the making of atomic bombs at Los Alamos, N. M.

Doctor Openheimer (now on the faculty of the California Institute of Technology) spoke at the first postwar Atomic Energy Conference held jointly by the American Philosophical Society and the National Academy of Sciences.

"We have made a thing," said Doctor Oppenheimer, "that has altered abruptly and profoundly the nature of the world.

"The atomic bomb is a very ordinary thing in some ways but—in a world of atomic weapons wars will cease.

"Because it is known the project cost us two billion dollars, and we dropped just two bombs, it is easy to think they must be expensive. But for any serious undertaking in atomic armament—and without any elements of technical novelty whatever, just doing things that have already been done, that estimate of cost would be high by something like a factor of one thousand. Atomic weapons, even with what we know today, can be cheap."

He said that except for the protecting hills the second bomb at Nagasaki would have "taken out" ten square miles or a little more. Great steel girders of factories were twisted and wrecked, he declared, and some of these wrecked factories were miles apart.

New medical discoveries from the atomic bomb were reported by Dr. Robert S. Stone, University of California. They were made in studying the rays emitted by thirty common chemical elements which are transformed into substances like radium.

---

* For editorial and other comment, see pp. 209-264, 298-304, and 309.

Beta rays, streams of electrons, were produced so powerful that a single overexposure of this radiation caused skin cancer in animals. These rays have long been known to cause cancer, but never in a single shot.

Some of the radioactive by-products, he said, if absorbed into the body, will cause sarcoma (cancer) of the bone. Plutonium, the new metal that makes bombs, is just as dangerous as radium if taken into the human body.—San Francisco *Examiner*, November 17.

Medics Urging Federal Support for Science Research Program

Washington.—(UP.)—Three medical scientists agreed today that the Federal Government should set up a science research foundation but urged that member scientists be free of unnecessary governmental restrictions.

One of the scientists, Dr. E. M. Macewon, dean of the Iowa University Medical college, told the joint Senate commerce and military affairs subcommittee that "the only defense against future wars will be scientific and industrial supremacy."

Dr. Macewon also told the committee, which is studying bills to create a national science foundation, that the Allies won the war "because time and the blunders of a paperhanger gave our scientists an opportunity to develop more accurate and destructive weapons. . . ."

"Next time we will have neither of these; science will strike when ready and perhaps without warning," he said. "A generation or less ago preparedness was expressed in an international armament race. Tomorrow it will be a race for scientific supremacy."

Dr. A. N. Richards, chairman of the committee on medical research of the Office of Scientific Research and Development, declared that "'if we do not wish to go scientifically bankrupt," scientists must be allowed to abandon the regimentation necessary during war.

"We must see to it that our (scientific) investigators return to their more deliberate habit; that they cease to be bedeviled by such requirements as that of bimonthly reports to an authority in Washington."—Merced *Sun-Star*, October 23.

British Medical Plan Is Scored

London, Nov. 12.—(INS.)—The *Daily Sketch* said today a Labor government bill bringing British hospitals under state control and specifying the areas in which physicians may practice will be introduced in parliament.

The newspaper said the bill was prepared without prior consultation with hospitals, local authorities or members of the medical profession.

The proposal, which exempts certain medical specialists, would restrict a family's choice of physicians to those in the immediate area and forbid the buying and selling of medical practices.

"Feudalism at its worst never indulged in such tyrannical folly as this," the newspaper declared.—Modesto *Bee*, November 12.

Dr. A. J. J. Rourke Named to Hospital Group

Dr. Anthony J. J. Rourke, physician superintendent of Stanford University Hospitals, has been appointed a member of the Council of Administrative Practice, it was announced yesterday by the American Hospital Association.

At the same time the Association announced the appointment of William P. Butler, manager of San Jose Hospital, as chairman of the Council on Association Relations. —San Francisco *Examiner*, November 19.

Heart Disease Research Set

New York, Nov. 1.—The life insurance industry announced today establishment of a $3,500,000 fund for a six-year medical research in the United States and Canada.

M. Albert Linton, chairman of the joint committee of the American Life Convention and the Life Insurance Association of America, said 143 insurance companies had pledged support of the program.

The first goal will be research into what was called the "No. 1 killer"—heart and arterial disease, causing roughly 30 per cent of all deaths annually.—San Francisco *News*, November 1.

Chiropractors and a Four Year Course

Sacramento, Nov. 20.—(AP.)—Directors of the California Chiropractic Association have adopted an educational requirement of a four-year course of study, Dr. Raymond L. Parker, chairman of the Association's legislative council, said today.—San Francisco *Chronicle*, November 21.

California Doctors Back Pre-Pay Plan

Chicago, Dec. 2.—The medical profession must take the lead in building up national health or "surrender the responsibility to those in whose hands we would not like to see it placed," Joseph H. Howard, Bridgeport, Conn., and Dr. Philip K. Gilman, San Anselmo, President of the California Medical Association, told the first annual conference of presidents and other officers of State Medical Societies today.

Condemning President Truman's proposed system of health insurance, Dr. Gilman said, however, that, "after the President's statement there is no longer any room for doubt about the necessity or wisdom of providing prepayment systems for meeting medical care costs."

"We must do something about it," he declared. "Today we (the medical profession) are forced to do something—something aggressive."

Both doctors concurred that "a need exists for better provision for building the national health" but insisted the better way of accomplishing this was through voluntary systems with participants having free choice of doctors and services.

Dr. Howard suggested that "the development of voluntary medical care program and the experience under these various programs can be consolidated to offer the right answer to the compulsory medical care program as advocated by President Truman."

The conference adopted a resolution calling for statewide health programs based on free choice of doctors and urged formation of a Department of Public Health and Medical Welfare with cabinet rank.—San Francisco *News*, December 3.

"Don't Curb Doctors," Says Medical Chief

Chicago, Dec. 3.—(UP.)—Major General Paul R. Hawley, medical director of the Veterans' Administration and Acting Surgeon General, tonight denounced any type of Government control of medicine, asserting the medical field "doesn't need the Government to tell it how" to solve its problems.

Hawley told the House of Delegates of the American Medical Association, now in session here, that "free and uncontrolled medicine will solve its own problems."

Hawley, who recently threatened to quit as Acting Surgeon General unless Congress approves General Omar Bradley's plan for veterans' hospitals, made no direct reference in his address to President Truman's universal medical care program. But he stated strongly he did not approve of any Government interference in the medical field.

V. A.'s Problem

He said the Veterans' Administration has an unprecedented job of treating thousands of veterans with an inadequate number of doctors.

He said private physicians would have to participate on a part time basis in veterans' hospitals and in private practice, receiving standard fees from the Veterans' Administration.

* * *

Earlier Dr. Herman L. Kretschmer of Chicago, retiring president, said Presi. ent Truman's proposed program, if enacted, would constitute the first step toward totalitarianism in this country.

"When will the Legislators, the do-gooders, and others learn that disease cannot be cured by the passage of laws?" he said. "The physicians of this country will never be regimented."

"Un-Amercian"

Dr. Kretschmer also directed the attention of the delegates to difficulties which he said are being placed in the path of returning Army and Navy doctors seeking to resume practice and urged that they be eliminated.

"Most hospital privileges," he said, "are contingent on membership in county medical societies. In some places, returning medical officers have been placed on what amounts to probation for one or two years. This practically closes the doors of hospitals to them, and the practice is unwarranted, unfair and un-American."

* * *

A resolution urging that voluntary non-profit state-wide health plans be established at once, with "free choice of purveyors of health care," was adopted at the first annual conference of presidents and other officers of state medical societies, attended by delegates from 37 states.

* * *

Also advocated was establishment of a Secretary of Health and Medical Care in the Cabinet, to be selected from practicing physicians, to direct "every Federal bureau and office whose duties are related to health and medical welfare."—San Francisco *News*, December 3.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

A Physician Has No Authority to Engage Another Physician For a Patient Which He is Attending in the Absence of Express Authority From the Patient

The Appellate Department of the Superior Court of Los Angeles County on November 13, 1945, in an action entitled McManus vs. Eymil rendered a decision involving the authority of an attendant physician to engage another physician as a consultant without express authority from his patient. The Court held that in the absence of such authority the consulting physician who was called in without express authority from the patient could not look to the patient for payment of his fee. The decision of the Court was as follows:

Dr. A admittedly was not engaged directly by defendant or defendant's daughter to take care of defendant's wife. He states that he visited the patient at the request of Dr. B, the attending physician, who had been employed by defendant.

The evidence was insufficient to show that Dr. B had express authority from either defendant or defendant's daughter to engage Dr. A as consulting physician. There is no showing that defendant had ever heard of Dr. A or knew of his services until he received a bill from him. There is no showing that defendant at any time ratified the employment of Dr. A or agreed to pay for his services.

In the absence of express authority, a physician employed to take care of a patient has no implied authority to engage another physician at his employer's expense without the latter's knowledge or consent. (Lindsay v. Freda (1923), 2 D.L.R. 1180; Webb v. Porto Rican American Tobacco Co. (1910), 16 Porto Rico 378, 388; Bond v. Hurd (1904), 31 Mont. 314, 78 P. 579, 582; Johnson v. Roberts (1925), 212 Ala. 535, 103 S. 563, 564; Wagner v. West Penn. Power Co. (1933), 110 Penn. Supp. 221, 168 Atl. 478, 480.) Of course, we are dealing with a case where it was not impossible to seek consent. (In this connection see Richter's Estate (1928), 11 Penn. D. & C. Rep. 485, 490.) There are no California cases on this point involving physicians, but in the analogous situation involving attorneys, the rule is well established that an attorney has no authority by virtue of his retainer to employ another attorney at the expense of his client without previous authority or assent of the client. (Cormac v. Murphy (1922), 58 Cal. App. 366, 369, and cases cited; Johnson v. California I.M.T. Assn. (1938), 24 Cal. App. 2d 322, 335, 340; see also 90 A.L.R. 265.)

No account stated was created between Dr. A and defendant by the fact that Dr. A sent bills to which defendant failed to object for several months. The creation of an account stated presupposes an existing debt between the parties. (Bennett v. Potter (1919), 180 Cal. 738, 745; Wine Packing Corp. v. Voss (1940), 37 Cal. App. 2d 528, 539.) As we have noted above, no such condition existed in this case.

The judgment is reversed and the cause is remanded for a new trial, appellant to recover his costs of appeal.

As noted in the opinion of the Court this is a decision of first impression in California although authorities to the same effect are cited in other jurisdictions. The result of the decision makes it apparent that in any case where an attending physician desires to call in a consultant the consultant should make arrangements for payment of his services with the attending physician or with the patient. If there is no express authority from the patient and employment by the patient of the consulting physician, he will not be permitted to collect a fee from the patient and will therefore have to look only to the attending physician for payment. It is therefore imperative that definite arrangements be made in advance so that misunderstandings of the type involved in the above case will be avoided.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

Government Medical Care System Declared Failure in New Zealand

Wellington (N.Z.)—Dec. 1.—In six years of operation New Zealand's system of state medical care has ballooned costs, jammed hospitals, promoted a physicians' racket of large dimensions and speeded the development of a nation of nostrum takers. It has not cut sickness and has not provided adequate medical service.

What happens when a nation goes over to free medical care is shown by figures covering admittances to the national hospital system. In 1932 admissions were 79,000; in 1944, latest year for which statistics are available, they were 171,000. Undoubtedly today they are higher.

More Difficult to Get

Yet today, despite a major wartime increase of hospital beds, the New Zealander who needs hospital attention finds it harder to get because the administrative chiefs say their beds are jammed with the aged and chronically ill, senile and other long-term patients who ordinarily would have received care at home, but today are dispatched to hospitals by families eager to be quit of them.

Coincidentally hospitals lack accommodations for such vital cases as tuberculosis sufferers who are crowded out by these permanent dwellers. Silverstream Hospital, near here, earlier operated by the American Navy to treat men of our force in the Solomons and now taken over by Wellington Hospital in an effort to relieve pressure, already is well filled with these cases.

Cost Multiplies

The sharply rising costs of medical care are shown in the fact that the Socialist government originally budgeted on the basis of $5,000,000 being sufficient annual payment for all physicians' services. Today the budget exceeds $25,000,000. In part this is laid to overconsultation of physicians by anxious patients whose opportunity of nursing their neuroses has been enlarged by the free system. . . .—Quentin Pope in Los Angeles *Times*, December 2.

Scientific Research—Some Comments

Although scientific researchers have existed since the days of ancient Greece, until the last three generations their numbers were so few and their activities so diverse that they were not often classified as members of the same profession. But with the organization of industrial research laboratories, having as their object the improvement of old, and the invention of new processes, products and machines, scientific research began to be regarded as a profession comparable to the profession of engineering, for example.

The field of industrial chemistry, notably in Germany, was perhaps the first in which professional researchers became relatively numerous. . . .

Herbert Hoover (in *The Times* of Sept. 19, 1940) said: "A thousand openings already beckon to action by applied science to use what we already know. Therefore the second step is more support to applied science research. We probably spend $200,000,000 on that, mostly through government and industry. But that is only 15 per cent of our cigarette bill, and with the depression that has slackened, whereas it should be increased."

The first step of which he spoke was research in pure science as to which he said: "And at once I come to the first step in industrial efficiency. That is more support to research in pure science. In all of our universities and our scientific institutions I doubt if we are spending $20,000,000 a year. That is about 7 per cent of our allowance for cosmetics." . . .—Halbert P. Gillette in Los Angeles *Times*, November 18.

We've Had Enough Czars

The proposal in the House Banking Committee to create a Federal "czar" to solve the housing shortage is better calculated to tie more knots in the problem. We have tried out a few "czars" during the war; the experience does not make us want more of them. Leave the "czars" to baseball; there they are that industry's own business; the public does not have to go to baseball games unless it wants to.

The public is in dire need of more housing. It wants houses, not czars, and right away. *General experience with governmental control is that it slows everything up with snarls of red tape, even where the intentions are the best in the world.* . . .—Excerpts from an editorial in San Francisco *Chronicle*, December 4.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVIII, No. 12, December, 1920

EXCERPTS FROM EDITORIAL NOTES

*An Ancient Opinion on the Physician.**—"Honour a physician according to thy need of him with the honours due unto him; for verily the Lord hath created him. For from the Most High cometh healing; and from the kind he shall receive a gift. The skill of the physician shall lift up his head; and in the sight of great men he shall be admired. The Lord created medicines out of the earth; and a prudent man will have no disgust at them. Was not water made sweet with wood, that the virtue thereof might be known? And he gave men skill, that they might be glorified in his marvelous works. With them doth he heal a man, and taketh away his pain. With these will the apothecary make a confection; and his works shall not be brought to an end; and from him is peace upon the face of the earth.

"My son, in thy sickness be not negligent; but pray unto the Lord, and he shall heal thee. Put away wrong doing, and order thine hands aright, and cleanse thy heart from all manner of sin. Give a sweet savour, and a memorial of fine flour; and make fat thine offering, as one that is not. Then give place to the physician, for verily the Lord hath created him; and let him not go from thee, for thou hast need of him. There is a time when in their very hands is the issue for good. For they also shall beseech the Lord, that he may prosper them in giving relief and in healing for the maintenance of life."

Cordial Congratulations, California!—We congratulate the people of California on the high character of intelligence and fine discrimination which they exercised on Propositions 5, 6, 7 and 8 on November 2, 1920. These four propositions which were popularly known as the "Quack Quartet" were promoted by the allied hosts of quackery, but despite the vast sums of money that they spent, despite the orgy of lurid literature and advertising, despite their mendacious mouthpieces, despite all the misrepresentation and ballyhooing of their combined forces up and down the highways and byways of the state, the people of California defeated them decisively. . . .

Reflections After the Battle.—The lesson of the campaign is above all else, now that our sinews are tried, that we have won a notable and tremendous victory, that the *struggle is but begun.* Each election, each session of the Legislature for a generation to come, will doubtless see attacks on public health and scientific medicine staged by the same old foes of both. The lesson of the campaign is that *organization* is an absolute essential for success and that we must fight in the future as hard as in the past. We have not finished. We have barely begun. These foes of health and scientific medicine are always with us. They must be controlled. This control depends on two things: an enlightened public and an organized medical

(Continued in Front Advertising Section, on Page 16)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

* From Ecclesiasticus XXXVIII. 1-14 verses.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held at 1020 N St., Sacramento, from October 15 to 18, 1945.

Written examinations were conducted and hearings were held on petitions for restoration of revoked certificates, as well as on revocation matters.

The following changes were made in the status of licentiates after regular hearings:

Bernard Aronchik, M.D. Certificate restored and he was placed on probation for a period of five years without narcotic privileges and with other specified terms;

William Brown Carr, M.D. Placed on probation for five years without alcoholic liquors and to report as specified in terms of probation;

Howard Doane Mayers, M.D. Certificate suspended for six months and placed on probation for additional five years without alcoholic liquors and to report as specified in terms of probation;

Norman Claude Smith, D.S.C. Placed on probation for five years without narcotic privileges and to report as specified in terms of probation.

News

"Raymond L. V. Silvio, 52, of 1405 Fourth Street was fined $500 today when he pleaded guilty to posing as a physician and selling 'medicines' brewed from fruit rinds and herbs to Sacramentans for as much as $39 a bottle. He was charged with practicing medicine without a license after his arrest by Joseph W. Williams, special agent of the board of Medical Examiners. Municipal Judge James M. McDonnell ordered Silvio to serve six months in the county jail in event he cannot pay the fine. Williams claims Silvio during the last two months has victimized more than fifty west end residents, selling medicines he made himself in the kitchen of the hotel where he resides. The concoctions were put up in used wine bottles and coffee jars, usually of one quart size, and sold for prices ranging from $26 to $39 a bottle." (Sacramento *Bee*, Sept. 28, 1945.)

"On a self-imposed fast at Lincoln Heights Jail is Prof. Alfred Jacob Newman who plans to forego his victuals until—well until . . . Born Yacov Raphael Novachovitch, Prof. Newman, who says he has practiced in Los Angeles for 13 years, described himself as a chiropractor, osteopath, naturopath, hydrotherapist, electropathist and neuropathist. He's in jail under conviction on three counts of violating the Business and Professions Code and one count of violating the Health and Safety Code. He was sentenced to pay a $250 fine or spend 50 days in jail on the first three counts, 90 days on the fourth count with the jail sentences to run concurrently. Drinking three or four quarts of water daily, so his stomach won't shrink, Prof. Newman reports that his weight is dropping about one pound a day. 'I'll continue to fast,' he vowed yesterday, 'until the judge allows my appeal or I am carried out of here on a stretcher.'" (Los Angeles *Times*, Oct. 8, 1945.)

(Continued from Front Advertising Section, Page 26)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

IT DOES HAPPEN HERE

Severe rickets still occurs — even in sunny climates

Vitamin D has become such an accepted practice in infant feeding that it is easy to think that rickets has been eradicated. However, even deforming rickets is still seen, as witness the above three contemporary cases from three different sections of the United States, two of them having well above the average annual sunshine hours for the country. In no case had any antiricketic been given during the first two years of life. *It is apparent that sunlight did not prevent rickets.* In other cases of rickets, cod liver oil was given inadequately (drop dosage) and even this was continued only during the winter months.

To combat rickets simply, inexpensively, effectively —

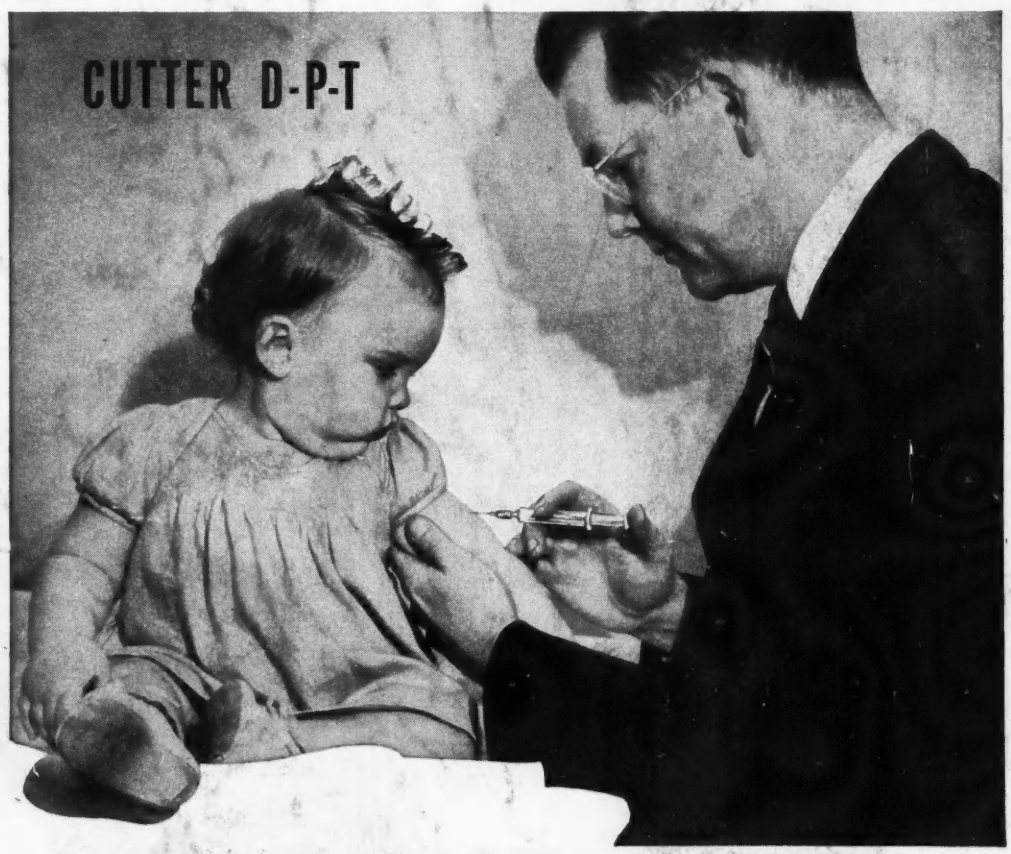
OLEUM PERCOMORPHUM

This highly potent source of natural vitamins A and D, if administered regularly from the first weeks of life, will not only prevent such visible stigmata of rickets as pictured above, but also many other less apparent skeletal defects that might interfere with good health. What parent would not gladly pay for this protection! And yet the average prophylactic dose of Oleum Percomorphum costs less than one cent a day. Moreover, since the dosage of this product is measured in drops, it is easy to administer Oleum Percomorphum and babies take it willingly. Thus there is assurance that vitamin D will be administered *regularly*.

EXIGENCY OF WAR

Oleum Percomorphum 50% is now known as Oleum Percomorphum With Other Fish Liver Oils And Viosterol. A source of vitamins A and D in which not more than 50% of the vitamin D is derived from viosterol. The potency remains the same; namely, 60,000 vitamin A units and 8,500 vitamin D units per gram.

MEAD JOHNSON & COMPANY, Evansville 21, Indiana, U. S. A.



"Combined immunization against diphtheria, tetanus, and pertussis is safe, effective and easy"★

BUT—not all combined vaccines are alike! Cutter D-P-T, used in the series reported above, is unique in many ways.

Organisms for the Pertussis Vaccine used in "D-P-T" are grown on *human blood media.* Purified toxoids and extremely high pertussis count yield a vaccine so concentrated that *every cc. contains considerably more than a human dose* each of tetanus and diphtheria toxoids — plus 40 billion pertussis organisms in Phase I. Thus, your dosage schedule with "D-P-T" is only 0.5 cc., 1 cc., 1 cc.

Cutter D-P-T (Alhydrox) is aluminum hydroxide adsorbed, determined by Miller to be more potent than aluminum precipitated vaccines. Moreover, persistent nodules and sterile abscesses are eliminated almost entirely.

Again quoting Miller, "Lapin has emphasized the danger of producing sterile abscesses when pertussis vaccine is mixed with alum toxoids. We are not in a position to comment . . . as aluminum hydroxide is the adsorbent used by us. In our group of 172 children who received 2 injections, no abscesses were noted."**

In time and embarrassment saved you, in pain saved your patients, you'll find Cutter D-P-T has much to offer.

★

Hamilton, P. M., and Knouf, E. G.; J. of Ped., 25:238; Sept. 1944. **Miller, J. J., and Saito, T. M.; J. of Ped., 21:31-44; July, 1942.

CUTTER LABORATORIES, BERKELEY, CALIF.

CUTTER

Fine Biologicals and Pharmaceutical Specialties